

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 will be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8804

08770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1yr 1mth 18dys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood, Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Rose</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1928</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fortune teller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Adams</u>		14. MOTHER'S MAIDEN NAME <u>Rose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging from tree with rope</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>around the neck</u> DUE TO (c) <u>Suicide</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>on 8-28-60, hanging from tree with rope around her neck</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. found at 3:25 p.m. on 8-28-60, hanging from tree with rope around her neck</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-28-60</u> Hour <u>3:25</u> P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) (County) (State) <u>Catonsville 28, Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo M. Kieffer</u>		DATE SIGNED <u>8-29-60</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>WASH</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Taltavull</u>		ADDRESS <u>3603 14th St NW</u>	
24a. REC'D BY REGISTRAR <u>AUG 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

82770

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. RACE [REDACTED]	
5. DATE OF BIRTH [REDACTED]		6. PLACE OF BIRTH [REDACTED]	
7. DATE OF DEATH [REDACTED]		8. PLACE OF DEATH [REDACTED]	
9. TIME OF DEATH [REDACTED]		10. CAUSE OF DEATH [REDACTED]	
11. MANNER OF DEATH [REDACTED]		12. SIGNATURE OF EXAMINER [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF CORONER [REDACTED]	
15. SIGNATURE OF JURY [REDACTED]		16. SIGNATURE OF JURY [REDACTED]	
17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	
19. SIGNATURE OF JURY [REDACTED]		20. SIGNATURE OF JURY [REDACTED]	
21. SIGNATURE OF JURY [REDACTED]		22. SIGNATURE OF JURY [REDACTED]	
23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JURY [REDACTED]	
25. SIGNATURE OF JURY [REDACTED]		26. SIGNATURE OF JURY [REDACTED]	
27. SIGNATURE OF JURY [REDACTED]		28. SIGNATURE OF JURY [REDACTED]	
29. SIGNATURE OF JURY [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF JURY [REDACTED]		32. SIGNATURE OF JURY [REDACTED]	
33. SIGNATURE OF JURY [REDACTED]		34. SIGNATURE OF JURY [REDACTED]	
35. SIGNATURE OF JURY [REDACTED]		36. SIGNATURE OF JURY [REDACTED]	
37. SIGNATURE OF JURY [REDACTED]		38. SIGNATURE OF JURY [REDACTED]	
39. SIGNATURE OF JURY [REDACTED]		40. SIGNATURE OF JURY [REDACTED]	
41. SIGNATURE OF JURY [REDACTED]		42. SIGNATURE OF JURY [REDACTED]	
43. SIGNATURE OF JURY [REDACTED]		44. SIGNATURE OF JURY [REDACTED]	
45. SIGNATURE OF JURY [REDACTED]		46. SIGNATURE OF JURY [REDACTED]	
47. SIGNATURE OF JURY [REDACTED]		48. SIGNATURE OF JURY [REDACTED]	
49. SIGNATURE OF JURY [REDACTED]		50. SIGNATURE OF JURY [REDACTED]	
51. SIGNATURE OF JURY [REDACTED]		52. SIGNATURE OF JURY [REDACTED]	
53. SIGNATURE OF JURY [REDACTED]		54. SIGNATURE OF JURY [REDACTED]	
55. SIGNATURE OF JURY [REDACTED]		56. SIGNATURE OF JURY [REDACTED]	
57. SIGNATURE OF JURY [REDACTED]		58. SIGNATURE OF JURY [REDACTED]	
59. SIGNATURE OF JURY [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF JURY [REDACTED]		62. SIGNATURE OF JURY [REDACTED]	
63. SIGNATURE OF JURY [REDACTED]		64. SIGNATURE OF JURY [REDACTED]	
65. SIGNATURE OF JURY [REDACTED]		66. SIGNATURE OF JURY [REDACTED]	
67. SIGNATURE OF JURY [REDACTED]		68. SIGNATURE OF JURY [REDACTED]	
69. SIGNATURE OF JURY [REDACTED]		70. SIGNATURE OF JURY [REDACTED]	
71. SIGNATURE OF JURY [REDACTED]		72. SIGNATURE OF JURY [REDACTED]	
73. SIGNATURE OF JURY [REDACTED]		74. SIGNATURE OF JURY [REDACTED]	
75. SIGNATURE OF JURY [REDACTED]		76. SIGNATURE OF JURY [REDACTED]	
77. SIGNATURE OF JURY [REDACTED]		78. SIGNATURE OF JURY [REDACTED]	
79. SIGNATURE OF JURY [REDACTED]		80. SIGNATURE OF JURY [REDACTED]	
81. SIGNATURE OF JURY [REDACTED]		82. SIGNATURE OF JURY [REDACTED]	
83. SIGNATURE OF JURY [REDACTED]		84. SIGNATURE OF JURY [REDACTED]	
85. SIGNATURE OF JURY [REDACTED]		86. SIGNATURE OF JURY [REDACTED]	
87. SIGNATURE OF JURY [REDACTED]		88. SIGNATURE OF JURY [REDACTED]	
89. SIGNATURE OF JURY [REDACTED]		90. SIGNATURE OF JURY [REDACTED]	
91. SIGNATURE OF JURY [REDACTED]		92. SIGNATURE OF JURY [REDACTED]	
93. SIGNATURE OF JURY [REDACTED]		94. SIGNATURE OF JURY [REDACTED]	
95. SIGNATURE OF JURY [REDACTED]		96. SIGNATURE OF JURY [REDACTED]	
97. SIGNATURE OF JURY [REDACTED]		98. SIGNATURE OF JURY [REDACTED]	
99. SIGNATURE OF JURY [REDACTED]		100. SIGNATURE OF JURY [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8805									
CERTIFICATE OF DEATH									
Reg. Dist. No. 08771									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LONG GREEN</u>			c. LENGTH OF STAY IN 1b <u>35 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GLEN ARM.</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 26 GLEN ARM P.O.</u>					d. STREET ADDRESS <u>Box 26 GLEN ARM P.O.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET ELIZABETH ALBRECHT</u>					4. DATE OF DEATH Month Day Year <u>AUG 30 1960</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 19, 1887</u>		9. AGE (In years last birthday) yrs. <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HENRY L. BARBOUR</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>105-10-7525B</u>		INFORMANT Address <u>CHARLES ALBRECHT, GLEN ARM P.O. BOX 26</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Atherosclerosis & Cor. Arty Dis.</u> (c) <u>Arteriosclerosis gen. d.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 1 yr.</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Mar 1960</u> to <u>Aug 1960</u> , that I last saw the deceased alive on <u>Aug 28, 1960</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Frank T. Kasik, M.D. 9005 Hartford Rd, Balto 14 Md 8/30/60</u>									
ACTUAL SIGNATURE <u>FRANK T. KASIK</u>			PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>SEPT 1, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home 7401 Belair Rd. #6. Md</u>					ADDRESS <u>Lassahn Funeral Home 7401 Belair Rd. #6. Md</u>		24a. REC'D BY REGISTRAR <u>AUG 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

11/20/71

CERTIFICATE OF DEATH

8028

MALE

WHITE

6-10-20

6-10-20

6-10-20

6-10-20

6-10-20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

8794

08772

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE COUNTY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANSDowne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 BALTIMORE COUNTY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>913 WINSAP COURT</u>		d. STREET ADDRESS <u>913 WINSAP COURT</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>HELEN</u> Middle <u>ALLEN</u> Last		4. DATE OF DEATH <u>Aug 7</u> Month <u>Aug</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1895</u> 9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Stewart</u>		14. MOTHER'S MAIDEN NAME <u>ANNA Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MR. VERNON E. ALLEN</u> Address <u>913 WINSAP COURT</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year <u>—</u> Hour <u>—</u> Minute <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 11, 1959</u> , to <u>August 6, 1960</u> , that I last saw the deceased alive on <u>Aug. 6, 1960</u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florian P. Nadolski</u>		DATE SIGNED <u>Aug. 8, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Florian P. Nadolski</u>		ADDRESS (Street, city or town, state) <u>Baltimore 27, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 10, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schuch</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
24a. REC'D BY REGISTRAR <u>Aug 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8806

CERTIFICATE OF DEATH

Reg. Dist. No.

08773

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall, R.D.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall, R.D.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>W.</u> Middle <u>Almon</u> Last <u>Y</u>		4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1892</u>
9. AGE (In years lost birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>	IF UNDER 24 HRS. Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Almon</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Quigley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>C. Franklin Almon</u>		Address <u>Towson, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular disease</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> to <u>Aug 2</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4-16-9-17</u> , 19 <u>60</u> , and that death occurred at <u>12</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>PARKTON, MD. 8/2/60</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		DATE SIGNED <u>8/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall, R.D., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Hartman</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>AUG 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

08730

CERTIFICATE OF DEATH

8308



8807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08774

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 114 Stevenson Lane		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 d. STREET ADDRESS 114 Stevenson Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JEAN Middle GRAHAM Last ANDREAE		4. DATE OF DEATH Month August Day 25 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1929
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 31 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard W. Gowdy		14. MOTHER'S MAIDEN NAME Ruth Graham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. C. Norman Andreae, Jr. - 114 Stevenson La.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism (acute) 888.0 DUE TO Overdose of sleeping pills Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested sleeping pills while intoxicated. Terminal episode was aspiration of stomach contents.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:00P p.m. 8/25/ 1960	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) nr. Balto. Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Wm. J. Telenor EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 26, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/27/60	22c. NAME OF CEMETERY OR CREMATORY Bruid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR Wm. J. Telenor & Sons - Balto. Md.		24a. REC'D BY REGISTRAR AUG 29 '60 24b. REGISTRAR'S SIGNATURE Carlin S. Kraus	

MEDICAL CERTIFICATION

08770

8807



RECEIVED
JAN 10 1960
U.S. DEPARTMENT OF HEALTH
BUREAU OF VETERANS AFFAIRS
WASHINGTON, D.C. 20460
MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]
DATE: [Illegible]
BY: [Illegible]
[Illegible text follows]

[Illegible text follows]

[Illegible text follows]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **8775**

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31 d. STREET ADDRESS 709 Van Lill Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACOB Middle -- Last ANDROCHEK		4. DATE OF DEATH Month August Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Phillip Androchek		14. MOTHER'S MAIDEN NAME Pearl Dirkach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md.		Address Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL, RIGHT PARAMEDIAN 903.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SUB-DURAL HEMORRHAGE DUE TO (c) CIRRHOSIS OF LIVER			INTERVAL BETWEEN ONSET AND DEATH 11 Days 11 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS OF LIVER			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell & Struck Head on Pavement	
20c. TIME OF INJURY Month, Day, Year Aug 11 1960 Hour 10:00 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Balto - Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M B Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) MELVIN B. DAVIS, M.D.		DATE SIGNED 8/11/60.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-16-60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
ADDRESS 6009 Harford Rd. Balto. 14, Md.		24b. REGISTRAR'S SIGNATURE C. L. H. H. H.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained by the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8809

CERTIFICATE OF DEATH

Reg. Dist. No.

08776

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 142 N. Linwood Ave - Baltimore 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 142 N. Linwood Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wesley Middle L Last Ashley		4. DATE OF DEATH Month Aug Day 11 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 13-1902
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Social Security	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Ashley		14. MOTHER'S MAIDEN NAME Mary M. Daniel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-09-0474	
17. INFORMANT Personal History		Address Hospital Records, Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Rt Lung DUE TO (b) 183X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1960 to Aug 11, 1960 , that I last saw the deceased alive on Aug 12, 1960 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milton B. Kress		M.D. Eudowood Sanatorium	
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D.		Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-15-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8810
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 7 Film 8-15-60 et

08777

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 43yr8mth27dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Ann Last Atkin		4. DATE OF DEATH Month August Day 9 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 11 Hours 40 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY England	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME John Rodgers		14. MOTHER'S MAIDEN NAME Levina Rodgers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 2, 1960 to Aug. 9, 1960 , that (I) (we) lost saw the deceased alive on Aug. 9, 1960 , and that death occurred on Aug. 9, 1960 at 3:40 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 8-9-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, or other DISPOSAL (Specify) BURIAL 8-11-60		23b. DATE THEREOF 8-11-60	
23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town, or county) (State) BALTO. CTY. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Sawicki		25a. REC'D BY REGISTRAR Aug 11 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Kraus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8811
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08778

1. PLACE OF DEATH o. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Baltimore County, Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b 4 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1010 Scotts Hill Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle A. Last Ball				4. DATE OF DEATH Month August Day 21 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1912	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Supervisor		11. BIRTHPLACE (State or foreign country) Ohio	
10b. KIND OF BUSINESS OR INDUSTRY Gas & Oil		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ernest I. Ball		14. MOTHER'S MAIDEN NAME Lela M. Mulberth - Columbus, Ohio	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 291-07-5994		17. INFORMANT Jo-Ann Ball		Address 1010 Scotts Hill Dr. Pikes. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Rheumatic Heart Disease, decomp. DUE TO (c) 5 yrs				INTERVAL BETWEEN ONSET AND DEATH 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 26 19 66 , to Aug 21 19 60 , that (I) was last saw the deceased alive on Aug 5 19 60 , and that death occurred at 6:25 M, from the causes and on the date stated above.							
22a. SIGNATURE Randolph H. Spitzberg M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug 21, 1960	
22c. PHYSICIAN'S NAME (Type) RANDOLPH H. SPITZBERG, MD				22d. ADDRESS 3806 Falls Kaff Rd 15, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-24-1960		23c. NAME OF CEMETERY OR CREMATORY Sunset Cemetery		23d. LOCATION (City, town, or county) (State) Columbus, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE Long Dykes				ADDRESS 8728 Liberty Road Randallstown, Maryland		25a. REC'D BY REGISTRAR DATE AUG 23 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Howard			

05778

CERTIFICATE OF DEATH

2011



Salisbury County, Maryland

Salisbury County, Maryland

17th & 18th Streets, Salisbury, Md.

Salisbury, Md.

JOHN ROBERT WILLIAMS

21 1900

August

Bell

A.

Charles

23

June 15, 1912

George

Wise

Male

Salisbury, Md.

Age 40

Married

John H. Williams - Salisbury, Md.

Married

21-07-2011 - on Bell - JOHN ROBERT WILLIAMS, JR.

20

Salisbury, Md.

Salisbury, Md.

Salisbury, Md.

Salisbury, Md.

Salisbury, Md.

Salisbury, Md.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8812
08779
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 45 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3701 DELVERNE ROAD	
3. NAME OF DECEASED (Type or print) First JOHN Middle F Last BARNARD		4. DATE OF DEATH Month AUGUST Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 19, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECH. ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY DISTILLERY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN BARNARD		14. MOTHER'S MAIDEN NAME MARGARET SLAUGHTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 185-07-6122	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIV		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA, ACUTE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) UNKNOWN DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Colon With Hepatomegaly due to Metastasis INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 6, 9:10 AM to August 20, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 20, 1960 , and that death occurred at AM , from the causes and on the date stated above.			
22a. SIGNATURE <i>L. B. Smith</i>		22b. DATE SIGNED 8-20-60	
22c. PHYSICIAN'S NAME (Type) L. B. SMITH		22d. ADDRESS M.D. VAH BALTIMORE MD Ft Howard Div	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 8-23-60	
23c. NAME OF CEMETERY OR CREMATORY NEW HARMONY CEMETERY		23d. LOCATION (City, town, or county) (State) NEW HARMONY, INDIANA	
24. FUNERAL DIRECTOR'S SIGNATURE FARLEY FUNERAL HOME		25a. REC'D BY REGISTRAR 6601 FREDERICK AVENUE CATONSVILLE 28, MD.	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>		DATE AUG 23 '60	

1877

CERTIFICATE OF DEATH

1877

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8813

Item 9 Baltimore 8-29-60 et

08780

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor		d. STREET ADDRESS 220 W. Lanvale St.	
3. NAME OF DECEASED (Type or print) First Middle Last Dr. Ernest J. Becker		4. DATE OF DEATH Month Day Year August 21 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1875
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Becker		14. MOTHER'S MAIDEN NAME Clara Muller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary Ditty 1307 Park Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of mouth & metastases DUE TO (b) 144X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular Disease			
INTERVAL BETWEEN ONSET AND DEATH 8 mos			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 21, 1960 to Aug 21, 1960 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9 PM , from the causes and on the date stated above.			
22a. SIGNATURE William F. Fritz			
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) WILLIAM F. FRITZ			
22b. DATE SIGNED 8/23/60			
22d. ADDRESS 2 W. UNIVERSITY PKWY.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-24-60	
23c. NAME OF CEMETERY OR CREMATORY Louisa Park		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR AUG 24 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles S. Kneass	

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STATE OF NEW YORK

8819

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8814

08781

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN 1b 21 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (13)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2414 East Biddle Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JAMES		First Middle Last A. BENTON		4. DATE OF DEATH Month August Day 26 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1920		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Extractor		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Augusta Benton				14. MOTHER'S MAIDEN NAME Hixie Pickett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 238-14-3263		17. INFORMANT Address Clinical Records, VAH, Balto. 18, Md. FORT HOWARD DIV.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary infarcts, recent and old.							INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 5 1960 to August 26 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 26 1960 , and that death occurred at 7:32 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Fredrick S. Donaldson				22b. DATE SIGNED 8/26/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTO. 18 MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/30/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR DATE SEP 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	

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MEDICAL CERTIFICATION

02381

STATE OF DEATH

831

NAME

DATE



PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

RELIGION

DATE OF DEATH

TIME OF DEATH

U.S.A.

LOCALITY

CITY

COUNTY



STATE

DEPARTMENT

DEPARTMENT OF HEALTH

OFFICE

NAME

ADDRESS

TELEPHONE

REMARKS

DATE OF DEATH

TIME OF DEATH

DEPARTMENT OF HEALTH

OFFICE

NAME

ADDRESS

TELEPHONE

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH First CEPHUS Middle BLANTON Last				4. DATE OF DEATH Month August Day 19 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5.2.1880.	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME HANSEL BLANTON				14. MOTHER'S MAIDEN NAME ELIZABETH SHEPPHARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Hospital Records, Mt. Wilson State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extremely far advanced bilateral ca- vitary pulmonary tuberculosis with destroyed left lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Anteriosclerotic heart disease DUE TO (c) Anteriosclerosis generalis							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8.4 , 19 60 , to 8.19 , 19 60 , that I last saw the deceased alive on 8.19 , 19 60 , and that death occurred at 11:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Newcomer				ADDRESS (Street, city or town, state) Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8-19-60		Protest Cemetery		Montgomery, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newcomer, Baltimore, Md.				24a. REC'D BY REGISTRAR SEP 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8816

CERTIFICATE OF DEATH

Reg. Dist. No.

08782

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		31014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home				d. STREET ADDRESS 5303 Wesley Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY HOLLINGSWORTH BOWERMAN				4. DATE OF DEATH Month Day Year August 14 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1865	
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Gibson				14. MOTHER'S MAIDEN NAME Caroline Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Walter N. Linthicum		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Anteroseptal cardiovascular disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 5 yrs +			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1960 , to 8-14-60 , 19 60 , that I last saw the deceased alive on 8-14-60 , 19 60 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St. Paul Street Balt. 2, Md DATE SIGNED 8-15-60							
ACTUAL SIGNATURE John A. Nesbitt, Jr.		M.D. John A. Nesbitt, Jr., M.D.					
PHYSICIAN'S NAME (Type) John A. Nesbitt, Jr., M.D.		1118 St. Paul Street Balt. 2, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/1960		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR ANG 17 '60		24b. REGISTRAR'S SIGNATURE Ellsworth Armacost	
25. FUNERAL HOME'S ADDRESS Ellsworth Armacost- 4600 Liberty Hgts. Ave.							

02582

CERTIFICATE OF DEATH

1914

Maryland

Baltimore

Baltimore

Cantonville

1914

1914

MARY HOLLINGSWORTH BOWENMAN

Nov. 25, 1914

Nov. 25, 1914

Maryland

At home

Caroline Taylor

William E. Gibson

1914

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8817

CERTIFICATE OF DEATH

Reg. Dist. No. 08783

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN lb <u>10 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>MARTIN</u> Last <u>BOWERS</u>		4. DATE OF DEATH <u>Aug 11 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMINE F. BOWERS</u>		14. MOTHER'S MAIDEN NAME <u>SARAH CATHERINE KIRBY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-05-6011</u>	
17. INFORMANT <u>Mrs. Edyth Patterson Bowers</u>		Address <u>Kingsville Rd. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Atherosclerotic Cardiovascular Dis 5 yrs.</u> DUE TO (b) <u>Atherosclerotic Cardiovascular Dis 5 yrs.</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X PULMONARY TUBERCULOSIS (1953+1954)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>7/37</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/37</u> , 19 <u>53</u> , to <u>8/11</u> , 19 <u>60</u> that I last saw the deceased alive on <u>8/10</u> , 19 <u>60</u> and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>		ADDRESS (Street, city or town, state) <u>FORK M.D.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		DATE SIGNED <u>8/11/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/13/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Fork Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Hunt</u>		24a. REC'D BY REGISTRAR <u>NOV 15 60</u>	
ADDRESS <u>Garrettsville Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1922

CERTIFICATE OF DEATH

1922



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PROVIDENCE, R.I.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8818

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08784

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nurs. Home 98 Smithwood Ave		d. STREET ADDRESS 634 North Bend Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary (Mollie) Bramble		4. DATE OF DEATH Month Day Year Aug. 10, 1960	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Watson		14. MOTHER'S MAIDEN NAME Mary E. Van Newkirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Helen R. Stevens 634 North Bend Rd, Catonsville 28, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blindness Chronic Brain Syndrome INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 15 1960 to 8/10/60 , that (I) was lost saw the deceased alive on 8/10/60 and that death occurred 6:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W.E. McGrath		22b. DATE SIGNED 8/11/60	
22c. PHYSICIAN'S NAME (Type) W.E. McGrath		22d. ADDRESS 1303 Frederick Rd (28)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 13, 1960	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemty.		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE AUG 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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4
8819
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home, Rolling Rd.		d. STREET ADDRESS 229 Clovelly Rd.	
3. NAME OF DECEASED (Type or print) First Eva Middle H. Brewer Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month Aug. Day 8 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William W.T. Hutchinson		14. MOTHER'S MAIDEN NAME Cleo Hancock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT John S. Hawkins		Address City, MD 229 Clovelly Rd. Ellicott	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cerebro-cardiovascular disease 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 19 8-8-60 , that (I) (we) last saw the deceased alive on 8-8-60 19 10:35 AM, from the causes and on the date stated above.			
22a. SIGNATURE John A. Nesbitt, Jr.		22b. DATE SIGNED Aug 9 '60	
22c. PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR		22d. ADDRESS 1118 St Paul St Baltimore 2, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Aug. 8/60	
23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION (City, town, or county) (State) Roanoke, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke, F.D. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE AUG 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

03752

CERTIFICATE OF DEATH

0013



Howard

Barling

Jefferson

Missouri City

Missouri City

Shed, 1000 Virginia Road, Rolling 40.880, 01/01/1917

Aug. 9/50

W. H. Hower

W. H. Hower

W. H. Hower

W. H. Hower

W. H. Hower

W. H. Hower

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W. H. Hower

W. H. Hower, 1000 Virginia Road, Rolling 40.880, 01/01/1917

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W. H. Hower

W. H. Hower

W. H. Hower

W. H. Hower, 1000 Virginia Road, Rolling 40.880, 01/01/1917

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FOR STATE
HEALTH DEPT.
(M)
X
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8820
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
08786

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparks				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Road off of Cold Bottom Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ESTELLE J. BROWN		First Middle Last		4. DATE OF DEATH August 23 1960		Month Day Year	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1938	
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse				10b. KIND OF BUSINESS OR INDUSTRY Hospital			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mr. M. Brown				14. MOTHER'S MAIDEN NAME Evelyn Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Wm. M. Brown				Address 1422 Railroad Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO (b) 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Apparently shot during case of homicide-suicide							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Apparently shot during case of homicide-suicide			
20c. TIME OF INJURY Month, Day, Year Oct. 5-6 8/22 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Auto				20f. (City or town) (County) (State) Baltimore Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/24/60							
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.				EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8/26/60 Pleasant Rest				22b. DATE THEREOF 8/26/60			
22c. NAME OF CEMETERY OR CREMATORY Pleasant Rest				22d. LOCATION (City, town, or country) (State) Towson Md.			
23. FUNERAL DIRECTOR Mr. L. L. Latham				24a. REC'D BY REGISTRAR AUG 26 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Knecht							

0532

10410

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8821

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

09920

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First HERMAN Middle L. Last BROWN		4. DATE OF DEATH Month August Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1922
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 09 Days 22	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		12. KIND OF BUSINESS OR INDUSTRY Farming	
13. FATHER'S NAME Frank Brown		14. MOTHER'S MAIDEN NAME Reola Ridley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 215-26-4616	
17. INFORMATION 3900 Loch Raven BLVBaltimore 18, Maryland		18. ADDRESS Clin. Rec. Vet. A Hospital, Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 465X ACUTE PULMONARY EDEMA DUE TO MULTIPLE PULMONARY EMBOLISMS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 Hour 1 Hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS -		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from July 29 60 , to August 31 60 , that (b) (we) last saw the deceased alive on Aug. 31 19 60 , and that death occurred at 11:30 p. m. from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson		22b. DATE SIGNED 9/2/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-5-60	
23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		23d. LOCATION (City, town, or county) (State) East New Market, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE St. Clair Funeral Home		25a. REC'D BY REGISTRAR SEP 14 '60	
ADDRESS Cambridge, Maryland		25b. REGISTRAR'S SIGNATURE Charles S. Haus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8822

CERTIFICATE OF DEATH

Reg. Dist. No. 88787

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8033 Highpoint Road</i>				d. STREET ADDRESS <i>8033 Highpoint Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Katherine</i> Middle <i>Edna</i> Last <i>Brown</i>				4. DATE OF DEATH Month <i>August</i> Day <i>4</i> Year <i>19 60</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-14-1903</i>	
9. AGE (In years lost birthday) <i>57</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George P. Streb</i>				14. MOTHER'S MAIDEN NAME <i>Johanna Ackerman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>199-1</i>		INFORMANT <i>Fred Brown</i> Address <i>same</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> 199-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>?</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>June</i> , 19 <i>60</i> , to <i>Aug 4</i> , 19 <i>60</i> that I last saw the deceased alive on <i>July 20</i> , 19 <i>60</i> , and that death occurred at <i>4:15</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Franklin E. Leslie</i> M.D. <i>2929 N. Charles Baltimore, Md.</i>							
ACTUAL SIGNATURE <i>Franklin E. Leslie</i>							
PHYSICIAN'S NAME (Type) <i>Franklin E. Leslie</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>							
22b. DATE THEREOF <i>8/8/60</i>							
22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>							
22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Hartford Rd.</i>							
24a. REC'D BY REGISTRAR DATE <i>AUG 5 '60</i>							
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>							

8822

CERTIFICATE OF DEATH

8822

[Faint, mostly illegible text on a form with multiple sections and lines for data entry. The text appears to be a mix of printed labels and handwritten entries, though the handwriting is too light to transcribe accurately.]

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Although this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

8823

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08788

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN 1b 21 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (26)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3421 Shellsun Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MOSES		First		Middle M.		Last BROWN	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month August Day 26 Year 1960	
8. DATE OF BIRTH November 13, 1916		9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie Brown				14. MOTHER'S MAIDEN NAME Levada Miles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 237-20-1575		17. INFORMANT Clinical Rec. VAH, Balto. 18, Md. FORT HOWARD DIV.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 592x IMMEDIATE CAUSE (a) UREMIA DUE TO CHRONIC GLOMERULONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, Generalized. Benign Prostatic Hypertrophy.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from August 5, 1960 to August 26, 1960 , that (X) (we) last saw the deceased alive on August 26, 1960 , and that death occurred at 10:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Fredrick S. Donaldson M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/26/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 29 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips ADDRESS 1808 N. Monroe St. Balto. 17 Md.				25a. REC'D BY REGISTRAR DATE SEP 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Arns	

8823

8823

Yessie Ann Johnson, born 11-11-1891, died 11-11-1981, age 89 years, 11 months, 1 day.

John A. Johnson, born 11-11-1891, died 11-11-1981, age 89 years, 11 months, 1 day.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8824

CERTIFICATE OF DEATH

Reg. No. 08789

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Normal Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mrs. Cecelia Middle M. Last Bryant		4. DATE OF DEATH Month August Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1865
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Shauck		14. MOTHER'S MAIDEN NAME Louisa Hubbard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
INFORMANT A. Thomas Bryant		Address 22 Normal Terrace, Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 to Aug 26 , 19 60 , that I last saw the deceased alive on July 29 , 19 60 , and that death occurred at 2:20 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Pillsbury M.D.		ADDRESS (Street, city or town, state) TIMONIAN, Md. DATE SIGNED 8/29/60	
PHYSICIAN'S NAME (Type) William A. Pillsbury			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 30, 1960	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		24a. REC'D BY REGISTRAR DATE AUG 30 '60	
ADDRESS 3631 Falls Road Balto, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

By: *[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8838

CERTIFICATE OF DEATH

8838



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

Page 4

8825

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08790

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 24yr10mth22dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1114 Hewitt Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lavinia Middle BUNCE Last Bunce				4. DATE OF DEATH Month 8 Day 12 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1903	
9. AGE (In years last birthday) 57 yrs.		10. UNDER 1 YEAR Months 57 Days 12 Hours 19 Min.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 593X IMMEDIATE CAUSE (a) Uremia DUE TO renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) nephritis DUE TO (c) gums infected				INTERVAL BETWEEN ONSET AND DEATH 4 days 11 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gums infected				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 6, 1960 to Aug. 12, 1960 that (I) (we) last saw the deceased alive on Aug. 12, 1960 , and that death occurred at 10:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE P. K. Yip				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) P. K. YIP, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried Aug-15-60				23b. DATE THEREOF Aug-15-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem	
23d. LOCATION (City, town, or county) (State) Balto. Md				23e. REC'D BY REGISTRAR AUG 17 '60			
24. FUNERAL DIRECTOR'S SIGNATURE John C. Meller				25. REGISTRAR'S SIGNATURE Arthur S. Kraus			

00730

CERTIFICATE OF DEATH

2825

M

1

1919

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8826

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08791

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Emp 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Catonsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 1273 Riverside Ave			
3. NAME OF DECEASED (Type or print) First Matilda Middle G. G. Last Burnett				4. DATE OF DEATH Month 8 Day 7 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2 1877	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties		10b. KIND OF BUSINESS OR INDUSTRY Germany		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Spring Grove St. Hosp. Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 904 Acute Cardiac Failure DUE TO (b) Cardio Vascular Heart disease DUE TO (c) fracture left femur Accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no history of injury all evidence of fracture						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 4 to 7 p.m. 8. 6. 60		20d. INJURY OCCURRED While on work <input type="checkbox"/> Not while on work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Grove St Hosp.		20f. (City or town) (County) (State) Catonsville Balto. Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo W. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-11-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Balto.	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. 130 E. Towler				ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 10 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE SIGNED Aug 7 1960	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8790 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08792

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22) c. LENGTH OF STAY IN lb 20 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 135 Ventnor Terrace		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22) d. STREET ADDRESS 135 Ventnor Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PARTICK Middle EDWARD Last BUTLER		4. DATE OF DEATH Month August Day 10th Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1893
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Mail Clerk	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Mary Cavanaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. none	
17. INFORMANT Ann M. Butler		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 CORONARY Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A-S-C-U-E DUE TO (c) Excess		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. B. Davis EXAMINER'S NAME (Type) Melvin B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. Dr. J. Collins ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 8/15/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md		24a. REC'D BY REGISTRAR DATE AUG 16 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

8827

CERTIFICATE OF DEATH

08793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHASE MARYLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHASE MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EBENEZER ROAD CHASE MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>F</u> Last <u>CARBACK</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 2, 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM CARBACK</u>	
14. MOTHER'S MAIDEN NAME <u>REBECCA COLLINS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>NORMAN CARBACK EBENEZER RD CHASE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>arterio sclerotic heart disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-24</u> , 19 <u>57</u> , to <u>5-20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-20</u> , 19 <u>60</u> , and that death occurred at <u>6:00a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Santi Amoroso</u> M.D.		ADDRESS (Street, city or town, state) <u>6801 Belair Rd, Balto #6, Md</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>8-23-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 25, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sassan Funeral Home</u>		ADDRESS <u>7401 Belair Rd Balto 6.</u>	
24a. REC'D BY REGISTRAR <u>AUG 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

08793

CERTIFICATE OF DEATH

1951

1

[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 8823 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

08794

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY 21-01-4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN 1b 27 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEO Middle B. Last CAVEY				4. DATE OF DEATH Month August Day 31 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH December 20, 1916	
9. AGE (In years lost birthday) 43 yrs.		IF UNDER 1 YEAR Months 43 Days 43 Hours 43 Min.		IF UNDER 24 HRS. Months 43 Days 43 Hours 43 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver				10b. KIND OF BUSINESS OR INDUSTRY Cab Company		11. BIRTHPLACE (State or foreign country) Ilchester, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Hugh B. Cavey				14. MOTHER'S MAIDEN NAME Nellie Frederick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II 215-10-5574		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FORT HOWARD DIV.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC AND RESPIRATORY INSUFFICIENCY DUE TO (b) GASTROINTESTINAL HEMORRHAGE DUE TO (c) DUE TO ULCER WITH PERFORATION (DUODENAL) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. S41-1							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Sclerosis. Operation - Partial Gastrectomy with gastro jejun-ostomy - 8/23/60							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from August 4, 1960 to August 31, 1960 , that (X) (we) last saw the deceased alive on August 31, 1960 , and that death occurred at 8:45 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE SIGNED 8/31/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 3, 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, 106 Columbia Rd. Ellicott City, Md.				25a. REC'D BY REGISTRAR SEP 2 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

8795

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haithorpe</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1802 Arbutus Ave</u>		d. STREET ADDRESS <u>1802 Arbutus Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph P. Clark</u>		4. DATE OF DEATH <u>Aug 1, 1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/1/19</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Clerk</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Barton Cotton, Inc. Maryland</u>	
13. FATHER'S NAME <u>Charles Clark</u>		14. MOTHER'S MAIDEN NAME <u>Flora Breeden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>220-01-0338</u>	
17. INFORMANT <u>Ruth C. Clark</u>		Address <u>1802 Arbutus Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>see to Coronary Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>59</u> to <u>Aug 1</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug 1</u> 19 <u>60</u> , and that death occurred at <u>12</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John C. Healy, M.D.</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John C. Healy M.D.</u>		22d. ADDRESS <u>1305 Francis Ave. 27.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/5/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc. 1328 Sulphur Spring Rd.</u>		25. REC'D BY REGISTRAR <u>DATE AUG 8 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles L. Knaus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8829
CERTIFICATE OF DEATH
08796

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 2yr10mth23dys d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 119 North Carey Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle Cordray Last Cordray		4. DATE OF DEATH Month August Day 29 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1881
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR: Months 78 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Barker		14. MOTHER'S MAIDEN NAME Olivia Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 28, 1960 to Aug. 29, 1960 , that (I) (we) last saw the deceased alive on Aug. 29, 1960 , and that death occurred at 3:10 p. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 8-29-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-31-60	
23c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.		23d. LOCATION (City, town, or county) (State) Bald Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fowler Funeral Home, Catonsville, Md.		25a. REC'D BY REGISTRAR SEP 7 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur E. House	

08730

CERTIFICATE OF DEATH

8428



MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
BOSTON, MASSACHUSETTS

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1893		BOSTON, MASS.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
123 MAIN ST. BOSTON		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 20 1938		10:15 AM		10:15		10:15		10:15	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8830

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08797

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE c. LENGTH OF STAY IN 1b LUTHERVILLE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 CAVAN DRIVE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE d. STREET ADDRESS 16 CAVAN DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle MAUDE Last CRABBE				4. DATE OF DEATH Month AUGUST Day 9 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 7, 1888	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) CANADA	
13. FATHER'S NAME PETER ELI				14. MOTHER'S MAIDEN NAME ESTER MC FERRAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS HAZEL CRABBE		Address 16 CAVAN DRIVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO myocardial Failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Rheumatoid arthritis - Osteoporosis DUE TO (c) Rheumatoid arthritis - Osteoporosis						INTERVAL BETWEEN ONSET AND DEATH 3 mos " " " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from July 1959 to aug 9 1960 , that (1) (we) last saw the deceased alive on aug 2 1960 , and that death occurred at 11 AM , from the causes and on the date stated above.							
22a. SIGNATURE George T. Gilmore				22b. DATE SIGNED 8/10/60		22c. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE	
22d. ADDRESS Lutherville, Maryland				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS Lutherville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL * TRANS		23b. DATE THEREOF 8/11/60		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL BURIAL PARK		23d. LOCATION (City, town, or county) (State) AKRON, OHIO	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons Jackson, Md.				25a. REC'D BY REGISTRAR DATE AUG 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Reg. Dist. No. 08798

8831

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gore Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Herbert Crawford</u>		4. DATE OF DEATH <u>August 10, 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1911</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meatcutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Butchering</u>	
11. BIRTHPLACE (State or foreign country) <u>Mountain City, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Lelia Lefler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>Yes</u>		16. SOCIAL SECURITY NO. <u>232-185033</u>	
17. INFORMANT <u>Mrs. Doris Jane Crawford, Freeland Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 minutes</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-21-</u> , 19 <u>57</u> , to <u>4-30-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-30-</u> , 19 <u>59</u> , and that death occurred at <u>1:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Robinson</u>		ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u> DATE SIGNED <u>8-10-60</u>	
PHYSICIAN'S NAME (Type) <u>R. ROBINSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-13-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MIDDLETOWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Hartman</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u> DATE <u>AUG 18 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8791
CERTIFICATE OF DEATH
08799

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 Patapsco Ave.				d. STREET ADDRESS 115 Patapsco Ave.			
3. NAME OF DECEASED (Type or print) First ANNA Middle KATHERINE Last DAIL				4. DATE OF DEATH Month August Day 22 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 22 Days 22 Hours 19 Min.		IF UNDER 24 HRS. Months 22 Days 22 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
3. FATHER'S NAME William Henry Thorn				14. MOTHER'S MAIDEN NAME Cassie Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO.		17. INFORMANT Howard T. Dail 2903 Dunbrin Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 442X DUE TO Hyper tension Cordis Vase Renalis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO 6.0 days 6. years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-52 to 8-22 19 60 , that (I) (we) last saw the deceased alive on 8-22 19 60 , and that death occurred at 143P M, from the causes and on the date stated above.							
22a. SIGNATURE Jack C Collins				22b. DATE SIGNED 8-23-60			
22c. PHYSICIAN'S NAME (Type) JACK C COLLINS				22d. ADDRESS 2 Kinslip BALT. 22 Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/25/60			
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City, town, or county) (State) Parkville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.				25a. REC'D BY REGISTRAR DATE AUG 24 '60			
				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

1870

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8832

CERTIFICATE OF DEATH

08800

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Manor				c. LENGTH OF STAY IN 1b 12 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5903 Queen Anne St.				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alice R. Dapkunas				4. DATE OF DEATH Month Aug. Day 30 , Year 1960			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 10, 1912		9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Max Kohn				14. MOTHER'S MAIDEN NAME Jeannie Purdy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Stanley Dapkunas 5903 Queen Anne St. Catonsville 28, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Bronchiogenic carcinoma DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1960 to Aug. 30, 1960 that (I) (we) last saw the deceased alive on Aug. 30, 1960 , and that death occurred at 7:55 PM from the causes and on the date stated above.							
22a. SIGNATURE Katharine V. Kemp				22b. DATE SIGNED 9/1/60		22c. PHYSICIAN'S NAME (Type) Katharine V. Kemp M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/3/60		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cmty	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir.				23d. LOCATION (City, town, or county) (State) A.A. Co. Md.		25a. REC'D BY REGISTRAR SEP 1 '60	
25b. REGISTRAR'S SIGNATURE Charles L. Hines							

08200

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

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8833

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08801

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1228 Leeds Terrace #27		d. STREET ADDRESS 1228 Leeds Terrace #27	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First C. Middle Howard Last Darling		4. DATE OF DEATH Month Aug. Day 3, Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. carrier		10b. KIND OF BUSINESS OR INDUSTRY Sunpaper	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Wesley		14. MOTHER'S MAIDEN NAME Mary E. Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-32-1931	
17. INFORMANT Nellie F. Darling		Address 1228 Leeds Terrace #27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate DUE TO 1777 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) & several carcinomas DUE TO 1/2 (c) Myocardial infarct 6 mo		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 1 yr 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1959 to Aug 3, 1960 that (I) met last saw the deceased alive on Aug 3, 1960 and that death occurred at 8 AM , from the causes and on the date stated above.			
22a. SIGNATURE Bruce Brumbaugh		22b. DATE SIGNED 8/4/60	
22c. PHYSICIAN'S NAME (Type) Bruce Brumbaugh, M.D.		22d. ADDRESS 5609 Main Street, Elkridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/6/60	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery Baltimore, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
25a. REC'D BY REGISTRAR AUG 5 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

08891

DEPARTMENT OF HEALTH

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8834

CERTIFICATE OF DEATH

08802

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colombia, South America b. COUNTY Cartagena c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calle Baloco # 7-48 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last HORTENSIA NUNEZ de CALVO				4. DATE OF DEATH Month Day Year August 15 1960													
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1901		9. AGE (In years lost birthday) yrs. 59		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Barrauquilla, Colombia, S.A. Colombia				12. CITIZEN OF WHAT COUNTRY? Colombia					
13. FATHER'S NAME Agustiu Nunez				14. MOTHER'S MAIDEN NAME Clementina Nunez				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---					
17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md., Fort Howard Division				Address													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUMOR, LEFT FRONTAL LOBE, UNSPECIFIED DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH UNKNOWN																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVING RISE TO DEATH Status following operation-radical mastectomy, left for carcinoma of breast. Operation 8/11/60 left prefrontal lobectomy, tumor left frontal lobe										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)													
21. I certify that (x) (this hospital) attended the deceased from August 11, 1960 to August 15, 1960 , that (x) (we) last saw the deceased alive on August 15, 1960 , and that death occurred at 9:25 A.M. from the causes and on the date stated above.																	
22a. SIGNATURE Frederick S. Donaldson M.D.				22b. DATE 8/15/60				22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTO. 18, MD., FORT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF Aug. 19, 1960				23c. NAME OF CEMETERY OR CREMATORY Municipal Cemetery				23d. LOCATION (City, town, or county) (State) Cartagena, Colombia, So. Amer.					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook				ADDRESS Blight, Inc. 6009 Harford Rd. Baltimore, Md.				25a. REC'D BY REGISTRAR AUG 24 '60				25b. REGISTRAR'S SIGNATURE Arthur L. Kline					

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Removal 10/19/1960
General Manager
Cincinnati, Ohio
10/19/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08803

Reg. Dist. No.

8835

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN lb 6yr2mth29dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 36 Hathaway Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Gabriel	First Dieumegarde	4. DATE OF DEATH Month August Day 14 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1903
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 5 Days 14	IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plumber		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	11. BIRTHPLACE (State or foreign country) U. S. A.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Louis Dieumegarde		14. MOTHER'S MAIDEN NAME Marie Lavale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Nat. Guard		16. SOCIAL SECURITY NO. 216-07-8761	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 921.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Foreign body found in mouth and esophagus and larynx DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) At 5:30 p. m. on 8-14-60 pt. was found dead abed with pieces of bread in his mouth and in the upper opening of the esophagus.	
20c. TIME OF INJURY Month, Day, Year 5:30 p. m. 8-14 19 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) (County) (State) Catonsville 28, Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-17-60	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or county) (State) Texas, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson		24a. REC'D BY REGISTRAR DATE AUG 16 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

World

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1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8836
CERTIFICATE OF DEATH
08804

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward M. Ditch Sr.				4. DATE OF DEATH Month Day Year August 1 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 28, 1888	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stage employee				10b. KIND OF BUSINESS OR INDUSTRY stage		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown Daniel Ditch				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-09-5817			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular accident DUE TO (c) Arteriosclerotic cardiovascular disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not white of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 22, 1960 to Aug. 1, 1960 , that (I) (we) last saw the deceased alive on Aug. 1, 1960 , and that death occurred at 10:25a M, from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar, M.D. M.D.				22b. DATE SIGNED 8-1-60			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Aug. 3, 1960		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home ADDRESS 3631 Falls Road				25a. REC'D BY REGISTRAR AUG 3 '60 DATE			
25b. REGISTRAR'S SIGNATURE W. F. Burgee							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10220

CERTIFICATE OF DEATH

8833



THE STATE

OF CALIFORNIA

DEPARTMENT OF HEALTH

County of _____

City of _____

State of _____

111

TO

12

3

711-1-117



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND8837
Item 1 Willm 260 4-25-60 et
CERTIFICATE OF DEATH

08895

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3101-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4320 Reisterstown Rd. - Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4320 Reisterstown Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Paul Last Dorman		4. DATE OF DEATH Month August Day 17 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897?
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) U/ S. A.		12. CITIZEN OF WHAT COUNTRY? U/ S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 15 1960 to Aug. 17 1960 that (I) (we) last saw the deceased alive on Aug. 17 1960 , and that death occurred at 8:25 M, from the causes and on the date stated above.			
22a. SIGNATURE Imre Kopits		22b. DATE SIGNED 8-17-60	
22c. PHYSICIAN'S NAME (Type) Imre Kopits, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, or other disposal (Specify) CREMATION		23b. DATE THEREOF 8-19-60	
23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION (City, town, or county) (State) BALTIMORE, MD	
24. FUNERAL DIRECTOR'S SIGNATURE WM COOK INC.		25a. REC'D BY REGISTRAR AUG 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08202

CERTIFICATE OF DEATH

2241

(M)

(1)

CHILDREN

ADULTS

WITNESSES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8833

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08896

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 month 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Margaret Last Doyle		4. DATE OF DEATH Month August Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1872
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Timothy Reardon		14. MOTHER'S MAIDEN NAME Johanna Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIAC VASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 20 1960 , to 1960 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE P. K. Yip			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) P. K. Yip, M.D.			
22d. ADDRESS Spring Grove State Hospital Catonsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Transit			
23b. DATE THEREOF 8/17/60			
23c. NAME OF CEMETERY OR CREMATORY Adams Cemetery			
23d. LOCATION (City, town, or county) (State) Adams, Mass.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			
ADDRESS Hyattsville, Md.			
25a. REC'D BY REGISTRAR DATE AUG 19 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

00220

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08807

8839

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson				c. LENGTH OF STAY IN 1b Rural Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				d. STREET ADDRESS Glenarm Road			
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Anacleto Drescher				4. DATE OF DEATH Month Day Year August 30 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1876	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bavaria, Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Drescher				14. MOTHER'S MAIDEN NAME Eva Tatis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Sister M. Peter Fourier Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio - sclerosis - hypertensive DUE TO (c) uremia				INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April , 19 60 , to August , 19 60 , that I last saw the deceased alive on August 25 , 19 60 , and that death occurred at 6.55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7501 York Road Towson 4, Md. 8/30/60							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D.							
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-1-60.		22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF M'R TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. Gail</i>				ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.		24a. REC'D BY REGISTRAR DATE SEP 2 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAHARAJA STATE DEPARTMENT OF HEALTH - BANGALORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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8840

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08808
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BELFAST RD.</u>				d. STREET ADDRESS <u>1 BELFAST RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL</u> <u>M.</u> <u>DRYDEN</u>				4. DATE OF DEATH Month Day Year <u>AUG.</u> <u>20</u> <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 3, 1903</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES CLERK - RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN C. YOST</u>				14. MOTHER'S MAIDEN NAME <u>LORETTA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <u>Mrs. E. B. Johnson - Belfast Rd. Sparks, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma of Right Colon</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 2nd</u> 1960, to <u>AUGUST 20th</u> 1960, that I last saw the deceased alive on <u>August 2nd</u> 1960, and that death occurred at <u>3 A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>M. K. Quinn</u> M.D. <u>1927 YORK RD</u> <u>8/20/60</u> PHYSICIAN'S NAME (Type) <u>M. K. QUINN MD.</u> <u>TIMONIUM</u> <u>Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Twiley Funeral Home - Catonsville, Md.</u>				ADDRESS <u>1927 YORK RD</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G271 9-14-60 et

8841

CERTIFICATE OF DEATH

Reg. Dist. No. 08809

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1707 Wilkins Avenue 1002 N. Holling Road 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS Baltimore, Md.	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ANNE Last DUVALL		4. DATE OF DEATH Month August Day 28 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1870
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Bowen		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Gordon S. Duvall, son, 2631 Chesterfield Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Canceroma, rt. upper eye lid		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1960, to 28 Aug , 1960, that I last saw the deceased alive on 27 Aug , 1960, and that death occurred at 9⁰⁰ A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Nesbitt, Jr.		ADDRESS (Street, city or town, state) 1118 St Paul St	
PHYSICIAN'S NAME (Type) JOHNA NESBITT, JR.		DATE SIGNED 8-29-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		24a. REC'D BY REGISTRAR DATE AUG 30 '60	
ADDRESS 3331 Brehms Lane		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8842

CERTIFICATE OF DEATH

Reg. Dist. No. 08810

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 10mth3dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Beulah Ruth Edwards		4. DATE OF DEATH Month 8 Day 4 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1891
9. AGE (In years last birthday) yrs. 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN George Reighter		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diaphragmatic Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dia betes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 1960 , to August 4, 1960 , that I last saw the deceased alive on August 4, 1960 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL 8-4-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 8, 1960	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		ADDRESS Baltimore Md.	
24a. REC'D BY REGISTRAR DATE AUG 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8843

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 29			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 815 S Warwick Ave				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Edward Engler Sr				4. DATE OF DEATH Month Day Year Aug. 22, 1960 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1908		9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder Better Food Machinery Md				10b. KIND OF BUSINESS OR INDUSTRY Md		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME ENGLE				14. MOTHER'S MAIDEN NAME Winnie Eberbach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 715-05-8696		17. INFORMANT Anna M Engler Address 815 S Warwick Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Cardio vascular heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, lawn, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE AUG 25 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kneib	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES H. HOPKINS		45		M		W		JAN 15 1880		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY		MILITARY SERVICE		NATIONALITY		CITIZENSHIP		RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
DRUGGIST		HIGH SCHOOL		MARRIED		METHODIST		DEMOCRAT		ARMY		AMERICAN		NATURALIZED		1234 E. 10th St.		JAN 20 1925		10:30 AM		HOSPITAL	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		HABITS		DIET		EXERCISE	
HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		PAIN IN CHEST		MEDICINE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
FINDINGS AT AUTOPSY		OPINION OF MEDICAL EXAMINER		SIGNATURE OF MEDICAL EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTY OF EXAMINATION		STATE OF EXAMINATION		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
LUNGS CONGESTED		DEATH DUE TO HEART DISEASE		JAMES H. HOPKINS		JAN 20 1925		HOSPITAL		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK		NEW YORK	

1

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8792
CERTIFICATE OF DEATH

08812
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 53			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 PORTSHIP ROAD				d. STREET ADDRESS 23 PORTSHIP ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID L. EVANS				4. DATE OF DEATH Month Day Year AUGUST 5 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 29, 1910	
9. AGE (In years lost birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LOUIS EVANS				14. MOTHER'S MAIDEN NAME SARAH JANE REESE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-07-4346-			
INFORMANT Address MRS MARY EVANS - 23 PORTSHIP							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 416X IMMEDIATE CAUSE (a) Rheumatic Heart Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 2, 1955 to Aug 5, 1960 , that I last saw the deceased alive on Aug 5, 1960 , and that death occurred at 11:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. R. Evans				ADDRESS (Street, city or town, state) 1 LIBERTY PARKWAY DATE SIGNED Aug 6, 1960			
PHYSICIAN'S NAME (Type) E. R. EVANS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 9, 1960		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) COLLEGE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME - DUNDALK MD				ADDRESS DUNDALK MD		24a. REC'D BY REGISTRAR AUG 9 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Kneass			

51280

885

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8793

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08813

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>25 Cottage Ave.</u>		d. STREET ADDRESS <u>25 Cottage Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>EVANS</u> Last		4. DATE OF DEATH <u>8-31-1960</u> Month <u>8-</u> Day <u>31-</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Prince Edward Co., Va. U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Josh Evans</u>		14. MOTHER'S MAIDEN NAME <u>Henretta</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO (b) <u>Generalized Art. Sclerosis</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>30 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack E Collins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack E Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-31-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph J. Collick</u> ADDRESS <u>1412 E. Preston St.</u>		24a. REC'D BY REGISTRAR <u>SEP 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneib</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville		c. LENGTH OF STAY IN 1b 12Y, 8M, 1D	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS MARYLAND HOUSE OF CORRECTION	
3. NAME OF DECEASED (Type or print) William First O. Middle Evans Last		4. DATE OF DEATH August Month 7 Day 1960 Year	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July -11- 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME George O. Evans		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Spring Grove records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) WITH HYPERTENSION DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year June 22nd 1960 Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 22nd 1960 to Aug. 8th 1960 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Patrick K. Yip		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Patrick K. Yip, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL BALTIMORE 28 MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-10-60	
23c. NAME OF CEMETERY OR CREMATORY Landon Park Cem		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Felix Funeral Home - Catonsville, Md.		25a. REC'D BY REGISTRAR AUG 11 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1921

CERTIFICATE OF BIRTH

8822



Ballinacree

Malabar

8

Spring Grove State Hospital

Welling House of Commons

William C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

John C. Evans

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 28</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of the Pines</u>				d. STREET ADDRESS <u>08815</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JANE CATHERINE FARRALL</u>				4. DATE OF DEATH Month Day Year <u>8 - 15 - 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 22, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>R. Earl Farrall, Waldorf, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>VASCULAR DISEASE</u> DUE TO (c) <u>10 YRS</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JANUARY 1950</u> to <u>5/10</u> , 1960, that I last saw the deceased alive on <u>8/14</u> , 1960, and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Phur & Beach</u> M.D. <u>3629 Edmondson Ave</u>				<u>8/10/60</u>			
PHYSICIAN'S NAME (Type) <u>Thas E Roach</u>				<u>BRYTOWN-MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The HUNT Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02815

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

1940

CLASS OF DEATH 1. Natural 2. Accidental 3. Suicide 4. Homicide 5. Unknown		PLACE OF DEATH 1. Home 2. Hospital 3. Prison 4. Other	
SEX 1. Male 2. Female		AGE 1. Under 1 year 2. 1 year to under 5 years 3. 5 years to under 15 years 4. 15 years to under 25 years 5. 25 years to under 35 years 6. 35 years to under 45 years 7. 45 years to under 55 years 8. 55 years to under 65 years 9. 65 years to under 75 years 10. 75 years and over	
RACE 1. White 2. Negro 3. Other		OCCUPATION 1. Professional 2. Managerial 3. Clerical 4. Service 5. Laborer 6. Unemployed 7. Other	
CAUSE OF DEATH 1. Heart disease 2. Cancer 3. Stroke 4. Lung disease 5. Kidney disease 6. Liver disease 7. Diabetes 8. Hypertension 9. Atherosclerosis 10. Other		MANNER OF DEATH 1. Natural 2. Accidental 3. Suicide 4. Homicide	
DATE OF DEATH 1. 1940 2. 1939 3. 1938 4. 1937 5. 1936 6. 1935 7. 1934 8. 1933 9. 1932 10. 1931 11. 1930 12. 1929 13. 1928 14. 1927 15. 1926 16. 1925 17. 1924 18. 1923 19. 1922 20. 1921 21. 1920 22. 1919 23. 1918 24. 1917 25. 1916 26. 1915 27. 1914 28. 1913 29. 1912 30. 1911 31. 1910 32. 1909 33. 1908 34. 1907 35. 1906 36. 1905 37. 1904 38. 1903 39. 1902 40. 1901 41. 1900 42. 1899 43. 1898 44. 1897 45. 1896 46. 1895 47. 1894 48. 1893 49. 1892 50. 1891 51. 1890 52. 1889 53. 1888 54. 1887 55. 1886 56. 1885 57. 1884 58. 1883 59. 1882 60. 1881 61. 1880 62. 1879 63. 1878 64. 1877 65. 1876 66. 1875 67. 1874 68. 1873 69. 1872 70. 1871 71. 1870 72. 1869 73. 1868 74. 1867 75. 1866 76. 1865 77. 1864 78. 1863 79. 1862 80. 1861 81. 1860 82. 1859 83. 1858 84. 1857 85. 1856 86. 1855 87. 1854 88. 1853 89. 1852 90. 1851 91. 1850 92. 1849 93. 1848 94. 1847 95. 1846 96. 1845 97. 1844 98. 1843 99. 1842 100. 1841 101. 1840 102. 1839 103. 1838 104. 1837 105. 1836 106. 1835 107. 1834 108. 1833 109. 1832 110. 1831 111. 1830 112. 1829 113. 1828 114. 1827 115. 1826 116. 1825 117. 1824 118. 1823 119. 1822 120. 1821 121. 1820 122. 1819 123. 1818 124. 1817 125. 1816 126. 1815 127. 1814 128. 1813 129. 1812 130. 1811 131. 1810 132. 1809 133. 1808 134. 1807 135. 1806 136. 1805 137. 1804 138. 1803 139. 1802 140. 1801 141. 1800 142. 1799 143. 1798 144. 1797 145. 1796 146. 1795 147. 1794 148. 1793 149. 1792 150. 1791 151. 1790 152. 1789 153. 1788 154. 1787 155. 1786 156. 1785 157. 1784 158. 1783 159. 1782 160. 1781 161. 1780 162. 1779 163. 1778 164. 1777 165. 1776 166. 1775 167. 1774 168. 1773 169. 1772 170. 1771 171. 1770 172. 1769 173. 1768 174. 1767 175. 1766 176. 1765 177. 1764 178. 1763 179. 1762 180. 1761 181. 1760 182. 1759 183. 1758 184. 1757 185. 1756 186. 1755 187. 1754 188. 1753 189. 1752 190. 1751 191. 1750 192. 1749 193. 1748 194. 1747 195. 1746 196. 1745 197. 1744 198. 1743 199. 1742 200. 1741 201. 1740 202. 1739 203. 1738 204. 1737 205. 1736 206. 1735 207. 1734 208. 1733 209. 1732 210. 1731 211. 1730 212. 1729 213. 1728 214. 1727 215. 1726 216. 1725 217. 1724 218. 1723 219. 1722 220. 1721 221. 1720 222. 1719 223. 1718 224. 1717 225. 1716 226. 1715 227. 1714 228. 1713 229. 1712 230. 1711 231. 1710 232. 1709 233. 1708 234. 1707 235. 1706 236. 1705 237. 1704 238. 1703 239. 1702 240. 1701 241. 1700 242. 1699 243. 1698 244. 1697 245. 1696 246. 1695 247. 1694 248. 1693 249. 1692 250. 1691 251. 1690 252. 1689 253. 1688 254. 1687 255. 1686 256. 1685 257. 1684 258. 1683 259. 1682 260. 1681 261. 1680 262. 1679 263. 1678 264. 1677 265. 1676 266. 1675 267. 1674 268. 1673 269. 1672 270. 1671 271. 1670 272. 1669 273. 1668 274. 1667 275. 1666 276. 1665 277. 1664 278. 1663 279. 1662 280. 1661 281. 1660 282. 1659 283. 1658 284. 1657 285. 1656 286. 1655 287. 1654 288. 1653 289. 1652 290. 1651 291. 1650 292. 1649 293. 1648 294. 1647 295. 1646 296. 1645 297. 1644 298. 1643 299. 1642 300. 1641 301. 1640 302. 1639 303. 1638 304. 1637 305. 1636 306. 1635 307. 1634 308. 1633 309. 1632 310. 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1531 411. 1530 412. 1529 413. 1528 414. 1527 415. 1526 416. 1525 417. 1524 418. 1523 419. 1522 420. 1521 421. 1520 422. 1519 423. 1518 424. 1517 425. 1516 426. 1515 427. 1514 428. 1513 429. 1512 430. 1511 431. 1510 432. 1509 433. 1508 434. 1507 435. 1506 436. 1505 437. 1504 438. 1503 439. 1502 440. 1501 441. 1500 442. 1499 443. 1498 444. 1497 445. 1496 446. 1495 447. 1494 448. 1493 449. 1492 450. 1491 451. 1490 452. 1489 453. 1488 454. 1487 455. 1486 456. 1485 457. 1484 458. 1483 459. 1482 460. 1481 461. 1480 462. 1479 463. 1478 464. 1477 465. 1476 466. 1475 467. 1474 468. 1473 469. 1472 470. 1471 471. 1470 472. 1469 473. 1468 474. 1467 475. 1466 476. 1465 477. 1464 478. 1463 479. 1462 480. 1461 481. 1460 482. 1459 483. 1458 484. 1457 485. 1456 486. 1455 487. 1454 488. 1453 489. 1452 490. 1451 491. 1450 492. 1449 493. 1448 494. 1447 495. 1446 496. 1445 497. 1444 498. 1443 499. 1442 500. 1441 501. 1440 502. 1439 503. 1438 504. 1437 505. 1436 506. 1435 507. 1434 508. 1433 509. 1432 510. 1431 511. 1430 512. 1429 513. 1428 514. 1427 515. 1426 516. 1425 517. 1424 518. 1423 519. 1422 520. 1421 521. 1420 522. 1419 523. 1418 524. 1417 525. 1416 526. 1415 527. 1414 528. 1413 529. 1412 530. 1411 531. 1410 532. 1409 533. 1408 534. 1407 535. 1406 536. 1405 537. 1404 538. 1403 539. 1402 540. 1401 541. 1400 542. 1399 543. 1398 544. 1397 545. 1396 546. 1395 547. 1394 548. 1393 549. 1392 550. 1391 551. 1390 552. 1389 553. 1388 554. 1387 555. 1386 556. 1385 557. 1384 558. 1383 559. 1382 560. 1381 561. 1380 562. 1379 563. 1378 564. 1377 565. 1376 566. 1375 567. 1374 568. 1373 569. 1372 570. 1371 571. 1370 572. 1369 573. 1368 574. 1367 575. 1366 576. 1365 577. 1364 578. 1363 579. 1362 580. 1361 581. 1360 582. 1359 583. 1358 584. 1357 585. 1356 586. 1355 587. 1354 588. 1353 589. 1352 590. 1351 591. 1350 592. 1349 593. 1348 594. 1347 595. 1346 596. 1345 597. 1344 598. 1343 599. 1342 600. 1341 601. 1340 602. 1339 603. 1338 604. 1337 605. 1336 606. 1335 607. 1334 608. 1333 609. 1332 610. 1331 611. 1330 612. 1329 613. 1328 614. 1327 615. 1326 616. 1325 617. 1324 618. 1323 619. 1322 620. 1321 621. 1320 622. 1319 623. 1318 624. 1317 625. 1316 626. 1315 627. 1314 628. 1313 629. 1312 630. 1311 631. 1310 632. 1309 633. 1308 634. 1307 635. 1306 636. 1305 637. 1304 638. 1303 639. 1302 640. 1301 641. 1300 642. 1299 643. 1298 644. 1297 645. 1296 646. 1295 647. 1294 648. 1293 649. 1292 650. 1291 651. 1290 652. 1289 653. 1288 654. 1287 655. 1286 656. 1285 657. 1284 658. 1283 659. 1282 660. 1281 661. 1280 662. 1279 663. 1278 664. 1277 665. 1276 666. 1275 667. 1274 668. 1273 669. 1272 670. 1271 671. 1270 672. 1269 673. 1268 674. 1267 675. 1266 676. 1265 677. 1264 678. 1263 679. 1262 680. 1261 681. 1260 682. 1259 683. 1258 684. 1257 685. 1256 686. 1255 687. 1254 688. 1253 689. 1252 690. 1251 691. 1250 692. 1249 693. 1248 694. 1247 695. 1246 696. 1245 697. 1244 698. 1243 699. 1242 700. 1241 701. 1240 702. 1239 703. 1238 704. 1237 705. 1236 706. 1235 707. 1234 708. 1233 709. 1232 710. 1231 711. 1230 712. 1229 713. 1228 714. 1227 715. 1226 716. 1225 717. 1224 718. 1223 719. 1222 720. 1221 721. 1220 722. 1219 723. 1218 724. 1217 725. 1216 726. 1215 727. 1214 728. 1213 729. 1212 730. 1211 731. 1210 732. 1209 733. 1208 734. 1207 735. 1206 736. 1205 737. 1204 738. 1203 739. 1202 740. 1201 741. 1200 742. 1199 743. 1198 744. 1197 745. 1196 746. 1195 747. 1194 748. 1193 749. 1192 750. 1191 751. 1190 752. 1189 753. 1188 754. 1187 755. 1186 756. 1185 757. 1184 758. 1183 759. 1182 760. 1181 761. 1180 762. 1179 763. 1178 764. 1177 765. 1176 766. 1175 767. 1174 768. 1173 769. 1172 770. 1171 771. 1170 772. 1169 773. 1168 774. 1167 775. 1166 776. 1165 777. 1164 778. 1163 779. 1162 780. 1161 781. 1160 782. 1159 783. 1158 784. 1157 785. 1156 786. 1155 787. 1154 788. 1153 789. 1152 790. 1151 791. 1150 792. 1149 793. 1148 794. 1147 795. 1146 796. 1145 797. 1144 798. 1143 799. 1142 800. 1141 801. 1140 802. 1139 803. 1138 804. 1137 805. 1136 806. 1135 807. 1134 808. 1133 809. 1132 810. 1131 811. 1130 812. 1129 813. 1128 814. 1127 815. 1126 816. 1125 817. 1124 818. 1123 819. 1122 820. 1121 821. 1120 822. 1119 823. 1118 824. 1117 825. 1116 826. 1115 827. 1114 828. 1113 829. 1112 830. 1111 831. 1110 832. 1109 833. 1108 834. 1107 835. 1106 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8846
CERTIFICATE OF DEATH
08816

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth30dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30014 f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle V. Last Fay		4. DATE OF DEATH Month August Day 31 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John T. Hennessey		14. MOTHER'S MAIDEN NAME Katherine V. Heaphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1960 to Aug. 31, 1960 , that (I) (we) last saw the deceased alive on Aug. 31, 1960 , and that death occurred at 11:55 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 9-1-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-3-60	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co		25a. REGISTERED SEP 2 1960	
ADDRESS 4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE SEP 2 1960	

8818

CERTIFICATE OF DEATH

8818

(M)

(1)

CHIEF CLERK

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8847

CERTIFICATE OF DEATH

Reg. Dist. No.

08817

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead R.D.</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Hampstead Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Twin</u> First <u>Twin</u> Middle <u>I</u> Last <u>Twin</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23-1960</u>
9. AGE (In years last birthday) <u>—</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Pleasant Hawble</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Tipton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Pleasant Hawble</u>		Address <u>Hampstead Md RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8:23</u> to <u>8:20</u> , that I last saw the deceased alive on <u>8-23</u> , 19 <u>60</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>HAMPSTEAD</u> DATE SIGNED <u>8/23/60</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		<u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 23/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Danell co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>		ADDRESS <u>Hampstead Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kneale</u>	



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health for or to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9-59

8848

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08818

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead - RFD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead - RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 7	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Tom Middle TWIN II Last Fowble		4. DATE OF DEATH Month August Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1960
9. AGE (In years last birthday) — yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. 10	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Pleasant Fowble		14. MOTHER'S MAIDEN NAME Evelyn Tipton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Pleasant Fowble, Hampstead, RFD, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 776X (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/23/ 19 60 to 8/20 19 60 , that (I) (we) last saw the deceased alive on 8/23/ 19 60 , and that death occurred at 12:45 PM from the causes and on the date stated above.			
22a. SIGNATURE M. C. Porterfield		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) M. C. Porterfield		22d. ADDRESS Hampstead, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 23, 1960	
23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton, Hampstead, Md.		25a. REC'D BY REGISTRAR DATE 1 1960	
25b. REGISTRAR'S SIGNATURE Walter S. Flansburg			

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08818

CERTIFICATE OF DEATH

8848

171



1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08819

8849

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consil	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3612 Lilac Ave.		e. STREET ADDRESS 3612 Lilac Ave.	
3. NAME OF DECEASED (Type or print) William A. Frey, Sr.		4. DATE OF DEATH Month Aug. Day 19 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Butcher	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles A. Frey	
14. MOTHER'S MAIDEN NAME Hesther Dundee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 218-01-5598		17. INFORMANT Address Mrs. Mary E. Frey-3612 Lilac Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 13 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 19, 1960 , to Aug 19, 1960 , that I last saw the deceased alive on Aug 19, 1960 , and that death occurred at 10:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Arthur Rossberg M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 2436 Washington Blvd 8/22/60	
PHYSICIAN'S NAME (Type) C. ARTHUR ROSSBERG		Baltimore 30 Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 23, 1960	22c. NAME OF CEMETERY OR CREMATORY St. John's	22d. LOCATION (City, town, or county) (State) Ellicott City Md.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury-6411 Windsor Mill Rd.		24a. REC'D BY REGISTRAR DATE AUG 23 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After a certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08820

8850

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 7</u>				c. LENGTH OF STAY IN 1b <u>6 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3610 LANDBECK RD</u>				d. STREET ADDRESS <u>3610 Landbeck Rd.</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>LOUISE</u> Last <u>GILES</u>				4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/13/1898</u>	
				9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edward Giles</u>				14. MOTHER'S MAIDEN NAME <u>Emma Durkin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-40-4863</u>		17. INFORMANT <u>M.R. CARD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175.0</u> DUE TO <u>Cerebral artery embolism.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emotion</u> (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1959</u> to <u>Aug. 13, 1960</u> , that I last saw the deceased alive on <u>July 12, 1960</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.				ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD, BALTO. 7, MD</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, MD</u>				DATE SIGNED <u>8/13/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickers & Sons - Balto</u>				24a. REC'D BY REGISTRAR <u>15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Pinner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08821

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>121 Winters Ave.</u>		d. STREET ADDRESS <u>121 Winters</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorothy Ann Gill</u>		4. DATE OF DEATH Month Day Year <u>Aug. 27 1960</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1892</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Warsaw Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Larwson</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Bailey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-67-7578</u>	
17. INFORMANT <u>Clara White</u>		Address <u>135 Winters Lane, Catonsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO 420.1 <u>Hypertensive cardio vascular heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>Aug. 27, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-31-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Joseph A. Lively</u>		ADDRESS <u>6614 Barre St Baltimore MD</u>	
24a. REC'D BY REGISTRAR <u>Aug 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>	

1920

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8851

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>		<p>5. Time of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>		<p>9. Signature of Medical Examiner: _____</p>	
<p>10. Signature of Coroner: _____</p>		<p>11. Signature of Registrar: _____</p>		<p>12. Signature of Burial Officer: _____</p>	
<p>13. Signature of Physician: _____</p>		<p>14. Signature of Nurse: _____</p>		<p>15. Signature of Undertaker: _____</p>	
<p>16. Signature of Witness: _____</p>		<p>17. Signature of Witness: _____</p>		<p>18. Signature of Witness: _____</p>	
<p>19. Signature of Witness: _____</p>		<p>20. Signature of Witness: _____</p>		<p>21. Signature of Witness: _____</p>	
<p>22. Signature of Witness: _____</p>		<p>23. Signature of Witness: _____</p>		<p>24. Signature of Witness: _____</p>	
<p>25. Signature of Witness: _____</p>		<p>26. Signature of Witness: _____</p>		<p>27. Signature of Witness: _____</p>	
<p>28. Signature of Witness: _____</p>		<p>29. Signature of Witness: _____</p>		<p>30. Signature of Witness: _____</p>	
<p>31. Signature of Witness: _____</p>		<p>32. Signature of Witness: _____</p>		<p>33. Signature of Witness: _____</p>	
<p>34. Signature of Witness: _____</p>		<p>35. Signature of Witness: _____</p>		<p>36. Signature of Witness: _____</p>	
<p>37. Signature of Witness: _____</p>		<p>38. Signature of Witness: _____</p>		<p>39. Signature of Witness: _____</p>	
<p>40. Signature of Witness: _____</p>		<p>41. Signature of Witness: _____</p>		<p>42. Signature of Witness: _____</p>	
<p>43. Signature of Witness: _____</p>		<p>44. Signature of Witness: _____</p>		<p>45. Signature of Witness: _____</p>	
<p>46. Signature of Witness: _____</p>		<p>47. Signature of Witness: _____</p>		<p>48. Signature of Witness: _____</p>	
<p>49. Signature of Witness: _____</p>		<p>50. Signature of Witness: _____</p>		<p>51. Signature of Witness: _____</p>	
<p>52. Signature of Witness: _____</p>		<p>53. Signature of Witness: _____</p>		<p>54. Signature of Witness: _____</p>	
<p>55. Signature of Witness: _____</p>		<p>56. Signature of Witness: _____</p>		<p>57. Signature of Witness: _____</p>	
<p>58. Signature of Witness: _____</p>		<p>59. Signature of Witness: _____</p>		<p>60. Signature of Witness: _____</p>	
<p>61. Signature of Witness: _____</p>		<p>62. Signature of Witness: _____</p>		<p>63. Signature of Witness: _____</p>	
<p>64. Signature of Witness: _____</p>		<p>65. Signature of Witness: _____</p>		<p>66. Signature of Witness: _____</p>	
<p>67. Signature of Witness: _____</p>		<p>68. Signature of Witness: _____</p>		<p>69. Signature of Witness: _____</p>	
<p>70. Signature of Witness: _____</p>		<p>71. Signature of Witness: _____</p>		<p>72. Signature of Witness: _____</p>	
<p>73. Signature of Witness: _____</p>		<p>74. Signature of Witness: _____</p>		<p>75. Signature of Witness: _____</p>	
<p>76. Signature of Witness: _____</p>		<p>77. Signature of Witness: _____</p>		<p>78. Signature of Witness: _____</p>	
<p>79. Signature of Witness: _____</p>		<p>80. Signature of Witness: _____</p>		<p>81. Signature of Witness: _____</p>	
<p>82. Signature of Witness: _____</p>		<p>83. Signature of Witness: _____</p>		<p>84. Signature of Witness: _____</p>	
<p>85. Signature of Witness: _____</p>		<p>86. Signature of Witness: _____</p>		<p>87. Signature of Witness: _____</p>	
<p>88. Signature of Witness: _____</p>		<p>89. Signature of Witness: _____</p>		<p>90. Signature of Witness: _____</p>	
<p>91. Signature of Witness: _____</p>		<p>92. Signature of Witness: _____</p>		<p>93. Signature of Witness: _____</p>	
<p>94. Signature of Witness: _____</p>		<p>95. Signature of Witness: _____</p>		<p>96. Signature of Witness: _____</p>	
<p>97. Signature of Witness: _____</p>		<p>98. Signature of Witness: _____</p>		<p>99. Signature of Witness: _____</p>	
<p>100. Signature of Witness: _____</p>		<p>101. Signature of Witness: _____</p>		<p>102. Signature of Witness: _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08822
Reg. Dist. No.

8796

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto Highlands</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2908 Keelmore ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Pauline</u> First <u>Ginter</u> Middle <u>Ginter</u> Last				4. DATE OF DEATH <u>Aug. 18</u> Month <u>Aug.</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15 1877</u> yrs. <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Ginter</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Knop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular heart disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo S M Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>23</u>		22b. DATE THEREOF <u>8-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto 25 MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Harris</u> ADDRESS <u>How 130 E Fort Ave</u>				24a. REC'D BY REGISTRAR <u>AUG 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4656

THIS IS A PERMANENT RECORD.
IF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8852

08823

1. NAME OF DECEASED (Type or Print) <i>William H Granger</i>		2. DATE OF DEATH <i>Aug 11/1960</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Baltimore County</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>6816 Campfield Road</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Rural Rockeard</i> D. STREET ADDRESS (If rural, give location) <i>16816 Campfield Road</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widower</i>	8. DATE OF BIRTH <i>Jan 2/1880</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Asst Supt Mail Ret</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>US Post Office</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>Joseph Granger</i>		14. MOTHER'S MAIDEN NAME <i>Rosa Mason</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Heriott Granger</i> ADDRESS <i>6816 Campfield Road</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <i>420.1 Coronary thrombosis</i> (A) DUE TO <i>Cardio-vascular disease</i> (B) DUE TO <i>advanced arteriosclerosis</i> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>about 2 hrs.</i> <i>about 5 yrs</i>
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19a. DATE OF OPERATION WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

22. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> 19 <i>55</i> to <i>Aug 11</i> 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>July 30</i> 19 <i>60</i> and that in (my) (our) opinion death occurred at <i>9:10</i> a.m., from the causes and on the date stated above.			
23a. SIGNATURE <i>Charles S Kibbett</i> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS <i>1501 Pentridge Rd</i>	23c. DATE SIGNED <i>Aug 11/60</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Entombment</i>	24b. DATE <i>Aug 15/1960</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i>	24d. LOCATION (City, town or county) (State) <i>Goodlawn Md</i>
25a. DATE REC'D BY HEALTH DEPT <i>AUG 12 1960</i>		25b. NAME OF REGISTRAR <i>Huntington Williams, M.D.</i>	25c. FUNERAL DIRECTOR <i>Harry A. Chmacek</i> ADDRESS <i>4204 Ridgebrook</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08824

8853

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Middle River #20

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Middle River #20

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

321 Grovethorn Road

d. STREET ADDRESS

321 Grovethorn Road

e. IS RESIDENCE
ON A FARM?YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

John L. Greenlee

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

August 4,

19 60

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

April 18, 1906

9. AGE (In years
last birthday)

54 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard

10b. KIND OF BUSINESS OR INDUSTRY

Aircraft

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel B. Greenlee

14. MOTHER'S MAIDEN NAME

Caroline Simpson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

Yes

WWII

16. SOCIAL SECURITY NO.

400-09-4657

17. INFORMANT

Mary Greenlee

Address

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
5 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. m.
p. m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Jack C Collins

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

JACK C Collins

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

8-6-60

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

8/8/60

22c. NAME OF CEMETERY OR CREMATORY

Balto. National Cemetery

22d. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

James Brundzinski
1407 Eastern Ave.

ADDRESS

24a. REC'D BY REGISTRAR

DATE AUG 9 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

FOR STATE
IN OFF



RECEIVED
JAN 10 1900
DEPT. OF HEALTH
Baltimore, Md.

1885

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON.

NAME OF DECEASED: JOHN J. WATSON

AGE: 40 YEARS

SEX: MALE

DATE OF DEATH: JAN 10 1900

PLACE OF DEATH: HOME

CAUSE OF DEATH: HEART DISEASE

DETAILS OF DEATH: HE HAD BEEN SICK FOR SEVERAL DAYS AND DIED AT HIS HOME.

SIGNATURE OF MEDICAL EXAMINER: JOHN J. WATSON

DATE: JAN 10 1900

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8854

CERTIFICATE OF DEATH

Reg. Dist. No.

08825

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix		c. LENGTH OF STAY IN 1b 11 life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stockton Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Taylor Griffith IV		4. DATE OF DEATH Month Day Year 8-4-60 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner-operator		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas T. Griffith		14. MOTHER'S MAIDEN NAME Louisa Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-30-8113	
17. INFORMANT R. Lloyd Smith		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio Vascular disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 yrs -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-3 , 19 60 , to 8-4 , 19 60 ; that I last saw the deceased alive on 8-4 , 19 60 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Herbert Mueller Jr. M.D.		ADDRESS (Street, city or town, state) York Rd., Hanford, Md. DATE SIGNED 8-5-60	
PHYSICIAN'S NAME (Type) C. HERBERT MUELLER Jr.		PARKTON P.O. MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-60	
22c. NAME OF CEMETERY OR CREMATORY Clynmalira Methodist		22d. LOCATION (City, town, or county) (State) Monkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE AUG 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

NOTIFICATION OF DEATH

1955

Baltimore, Maryland

Phoenix, Arizona

Stockton, CA

Thomas Taylor Griffith IV

white male 11-16-1921

owner-operator Baltimore, Maryland

Thomas T. Griffith

210-10-8113 R. Lloyd Smith above

Survival 8-8-60 Cymelina Methodist, Houston, TX

Brooks Funeral Service, Houston, TX

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

8855

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08826

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN lb 118 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1916 Mount Royal Terrace (17)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle Elwood Last GRIMSLEY				4. DATE OF DEATH Month August Day 17 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 27, 1891	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min. 00		IF UNDER 24 HRS. Hours 00 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Retired				10b. KIND OF BUSINESS OR INDUSTRY Real Estate Board		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Patrick Grimsley				14. MOTHER'S MAIDEN NAME Lorena Groves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. Card lost		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Unknown (c) Unknown				INTERVAL BETWEEN ONSET AND DEATH 48 Hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular Accident - Left Middle Cerebral Artery, Right Hemiparesis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from April 21, 1960 , to August 17, 1960 , that (X) (we) last saw the deceased alive on August 17, 1960 , and that death occurred at 6:15 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 8/17/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-20-60		23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Covager				ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR AUG 23 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

10000

CERTIFICATE OF DEATH

10000



()



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8856

CERTIFICATE OF DEATH

08827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Perry Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4124 Baker Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>C.</u> Last <u>Halpin</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18 1867</u>
9. AGE (In years, last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min. <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Ann Waters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-50770</u>	
17. INFORMANT <u>Catherine R. Kendall</u>		Address <u>4124 Baker Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO <u>Unlabeled Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Cardiac Failure</u> (c) <u>Cardiac Failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Int. S.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/20</u> , 19 <u>60</u> , to <u>8/27-60</u> , that I last saw the deceased alive on <u>8-26-60</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fred Ruzic</u> M.D.		ADDRESS (Street, city or town, state) <u>1011 N Charles St</u> DATE SIGNED <u>Aug 29 1960</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK RUZIC MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 30 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK RD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DIPPEL BROS</u> ADDRESS <u>7110 BELAIR RD</u>		24a. REC'D BY REGISTRAR <u>AUG 29 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8857

CERTIFICATE OF DEATH

08828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8003 Jacqueline Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>John</i> Last <i>Hartmann</i>		4. DATE OF DEATH Month <i>Aug.</i> Day <i>29</i> Year <i>19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-27-1882</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ice business</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Adam G. Hartmann</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Justice</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>Luella M. Hartmann</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>16 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 7/60</i> to <i>Aug 29/60</i> , that I last saw the deceased alive on <i>Aug 29/60</i> , 19 <i>8:15 PM</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry C. Houch</i> M.D. <i>1929 Wm 17 C</i>		ADDRESS (Street, city or town, state) <i>8/30/60</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>9-3-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR <i>Aug 31 60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

CERTIFICATE OF DEATH

1883



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[Faint handwritten text, possibly a name or address]

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 10yr5mth5dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3608 Rosedale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle R. Last Henderson, Jr.				4. DATE OF DEATH Month August Day 14 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1923	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months — Days —		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland S. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James R. Henderson, Sr.				14. MOTHER'S MAIDEN NAME Florence Ellis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 163-05-9369		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status convulsivus DUE TO Cerebral and dural adhesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Transfrontal Lobotomy DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Hour 3:00 p. m. Month, Day, Year 8-14 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Kieffer & Son				ADDRESS 110 Park Ave 17		24a. REC'D BY REGISTRAR DATE AUG 16 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

08330

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF REGISTRAR	
JAMES J. HONAN		M		45		W		1940		10:30 AM		1000 W. 10th St. Boston		Heart Disease		Natural		J. J. Honan		J. J. Honan		J. J. Honan	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. DATE OF ENTRY		16. DATE OF DEPARTURE		17. DATE OF RETURN		18. DATE OF DEATH		19. DATE OF DEATH		20. DATE OF DEATH		21. DATE OF DEATH		22. DATE OF DEATH		23. DATE OF DEATH		24. DATE OF DEATH	
New York		1900		1900		1900		1900		1940		1940		1940		1940		1940		1940		1940	
25. DATE OF DEATH		26. DATE OF DEATH		27. DATE OF DEATH		28. DATE OF DEATH		29. DATE OF DEATH		30. DATE OF DEATH		31. DATE OF DEATH		32. DATE OF DEATH		33. DATE OF DEATH		34. DATE OF DEATH		35. DATE OF DEATH		36. DATE OF DEATH	
1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940	
37. DATE OF DEATH		38. DATE OF DEATH		39. DATE OF DEATH		40. DATE OF DEATH		41. DATE OF DEATH		42. DATE OF DEATH		43. DATE OF DEATH		44. DATE OF DEATH		45. DATE OF DEATH		46. DATE OF DEATH		47. DATE OF DEATH		48. DATE OF DEATH	
1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940	
49. DATE OF DEATH		50. DATE OF DEATH		51. DATE OF DEATH		52. DATE OF DEATH		53. DATE OF DEATH		54. DATE OF DEATH		55. DATE OF DEATH		56. DATE OF DEATH		57. DATE OF DEATH		58. DATE OF DEATH		59. DATE OF DEATH		60. DATE OF DEATH	
1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940	
61. DATE OF DEATH		62. DATE OF DEATH		63. DATE OF DEATH		64. DATE OF DEATH		65. DATE OF DEATH		66. DATE OF DEATH		67. DATE OF DEATH		68. DATE OF DEATH		69. DATE OF DEATH		70. DATE OF DEATH		71. DATE OF DEATH		72. DATE OF DEATH	
1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940	
73. DATE OF DEATH		74. DATE OF DEATH		75. DATE OF DEATH		76. DATE OF DEATH		77. DATE OF DEATH		78. DATE OF DEATH		79. DATE OF DEATH		80. DATE OF DEATH		81. DATE OF DEATH		82. DATE OF DEATH		83. DATE OF DEATH		84. DATE OF DEATH	
1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940	
85. DATE OF DEATH		86. DATE OF DEATH		87. DATE OF DEATH		88. DATE OF DEATH		89. DATE OF DEATH		90. DATE OF DEATH		91. DATE OF DEATH		92. DATE OF DEATH		93. DATE OF DEATH		94. DATE OF DEATH		95. DATE OF DEATH		96. DATE OF DEATH	
1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940	
97. DATE OF DEATH		98. DATE OF DEATH		99. DATE OF DEATH		100. DATE OF DEATH		101. DATE OF DEATH		102. DATE OF DEATH		103. DATE OF DEATH		104. DATE OF DEATH		105. DATE OF DEATH		106. DATE OF DEATH		107. DATE OF DEATH		108. DATE OF DEATH	
1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940	
109. DATE OF DEATH		110. DATE OF DEATH		111. DATE OF DEATH		112. DATE OF DEATH		113. DATE OF DEATH		114. DATE OF DEATH		115. DATE OF DEATH		116. DATE OF DEATH		117. DATE OF DEATH		118. DATE OF DEATH		119. DATE OF DEATH		120. DATE OF DEATH	
1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940		1940	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88599 CERTIFICATE OF DEATH

Reg. Dist. No. 08830

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>27 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Carmel Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Virginia</u> Last <u>Herbert</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 17, 1932</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Scott Mays</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bruehl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>John M. Herbert, Parkton, Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199-2</u> DUE TO <u>Metastatic Carcinoma - generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO <u> </u> (c) DUE TO <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>August 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 24</u> , 19 <u>60</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Herbert Mueller Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Hereford - Parkton, P.O. box</u> DATE SIGNED <u>8/25/60</u>	
PHYSICIAN'S NAME (Type) <u>E. HERBERT MUELLER JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 27, 1960</u>	<u>Stablersville Cem.</u>	<u>Parkton, Md. R.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>AUG 29 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1880

CERTIFICATE OF DEED

1880

RECEIVED
JAN 10 1881
U.S. DEPT. OF THE INTERIOR

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8860

CERTIFICATE OF DEATH

08831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Road</u>		d. STREET ADDRESS <u>Old York Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edmund Wheeler Holmes</u>		4. DATE OF DEATH <u>August 26</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 March 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Lumbria, Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Holmes</u>		14. MOTHER'S MAIDEN NAME <u>Maggie M. Coy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-X-402</u>	
17. INFORMANT <u>Wife - Mary Jane</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. S. C. U. D.</u> DUE TO . Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4-22-1</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1960</u> to <u>Aug 1960</u> , that I last saw the deceased alive on <u>25 August 1960</u> , and that death occurred at <u>4:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.		ADDRESS (Street, city or town, state) <u>Cockeysville 26 August 60</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>WALTER T. KEEES</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		24a. REC'D BY REGISTRAR <u>Aug 31 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8861 CERTIFICATE OF DEATH 08832

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 28 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FERRIS Middle E. Last HOOD				4. DATE OF DEATH Month August Day 14 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1896	
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Severn, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver				10b. KIND OF BUSINESS OR INDUSTRY Trucking			
13. FATHER'S NAME John Hood				14. MOTHER'S MAIDEN NAME Rosetta Lowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 219-16-0963			
17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. Ft. Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from July 17, 1960 to August 14, 1960 , that (X) (we) last saw the deceased alive on August 14, 1960 , and that death occurred at 11:25 PM from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson				22b. DATE 8/15/60			
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8-18-60			
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery				23d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				25a. REC'D BY REGISTRAR AUG 24 1960			
25b. REGISTRAR'S SIGNATURE William S. Knapp							

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CERTIFICATE OF DEATH

Reg. Dist. No.

08833

8862

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5648 Calyn Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>L.</u> Last <u>HUGHES, SR.</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1895</u>	9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crown, Cork Seal</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles H. Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Hyland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>207-01-7676</u>		INFORMANT <u>Mrs. Viola Doering</u> Address <u>3811 Woodley Ave. Balto.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>183X</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>32 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Periton</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 8/30</u> , 19 <u>60</u> , to <u>8/31</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>8/30</u> , 19 <u>60</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James Nolan</u>				DATE SIGNED <u>9/1/60</u>			
PHYSICIAN'S NAME (Type) <u>J. J. NOLAN M.D.</u>				ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave Baltimore Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-3-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Co</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Kenny, Inc.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]

Page 4

VR AIS (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08834

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate				c. LENGTH OF STAY IN 1b X Colgate			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 7287 Bridgwood Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Clinton S Hutchinson				4. DATE OF DEATH Month Day Year August 11/60 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 13 1898		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY S K Co		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W Hutchinson				14. MOTHER'S MAIDEN NAME Margaret Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W W 11 213 05 2566		17. INFORMANT Mrs Margaret Hutchinson Address 7287 Bridgwood Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 196.2 196.2 Branchial Cyst Carcinoma DUE TO Metastatic Carcinoma of Spine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 mos (c) 3 yrs INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1 1960 to Aug. 12 1960 , that (I) (we) last saw the deceased alive on Aug. 12 1960 , and that death occurred at 12 M, from the causes and on the date stated above.							
22a. SIGNATURE John V. Sczerbicki				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John V. Sczerbicki				22d. ADDRESS 1802 Eastern Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Aug 15 /60		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Co	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home				25a. REC'D BY REGISTRAR AUG 16 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
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Page 4
TO MEDICAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8865

Item 16 File 4269 8-15-60 et

08836

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 105 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 705 PIN ALLEY	
3. NAME OF DECEASED (Type or print) Served As: Calvin First Middle Last CALVIN Jarrett JARAD		4. DATE OF DEATH Month AUGUST Day 5 Year 1960	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 18, 1899
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co	
11. BIRTHPLACE (State or foreign country) Texas, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie Jarad		14. MOTHER'S MAIDEN NAME Gertie Gibbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clin. Rec. VAH Balto 18, Md Ft Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG WITH METASTASES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 22, 1960 to August 5, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 5, 1960 , and that death occurred 1:15 PM from the causes and on the date stated above.			
22a. SIGNATURE Paul G. Koukoulas M.D.		22b. DATE SIGNED 8-7-60	
22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS		22d. ADDRESS VAH BALTO 18, MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/10/60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE George W Queen		25a. REC'D BY REGISTRAR DATE AUG 9 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Frank			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G268 8-8-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08837

8866

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 29 <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>56 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Asbestos</u> 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>937 Elmridge Ave</u>				d. STREET ADDRESS <u>937 Elmridge Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>C. Katherine Jaras</u>				4. DATE OF DEATH Month Day Year <u>Aug 1 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 2 1883</u>	
9. AGE (In years last birthday) yrs. <u>77</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>		9. AGE (In years last birthday) yrs. <u>77</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuanian</u>				12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-054248</u>		17. INFORMANT <u>Petras Jaras</u> Address <u>937 Elmridge Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO <u>Hypertension, arteriosclerosis C.V.D. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8-15-59</u> , 19 <u>59</u> , to <u>Aug 1 1960</u> , that I last saw the deceased alive on <u>August 1</u> , 19 <u>60</u> , and that death occurred at <u>10:15</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albin Klimas</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2030 W. Kenz Ave, Balto 23</u>			
PHYSICIAN'S NAME (Type) <u>ALBINAS KLIMAS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 4 1960</u>		<u>Lawton Park</u>		<u>Frederick Ave Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Kachauskas</u>				ADDRESS <u>6372 West Blk</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 5 1960</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8867

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKDALE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKDALE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3513 ELLEN ROAD</u>		d. STREET ADDRESS <u>3513 ELLEN RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>EARLY</u> Middle <u>HYTER</u> Last <u>JOHNSON JR.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 28 1916</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRIVER SALESMAN RICE'S BAKERY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EARLY H. JOHNSON SR.</u>		14. MOTHER'S MAIDEN NAME <u>GRACE KELLAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>215-09-655</u>	
17. INFORMANT <u>JANET M. JOHNSON - SAME</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS - ACUTE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u>		DATE SIGNED <u>August 4 1960</u>	
EXAMINER'S NAME (Type) <u>Clarence E. McWilliams M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-8-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>	
ADDRESS <u>8728 Liberty Road</u> <u>Randallstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8868
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08839

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN lb 7 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore (19) d. STREET ADDRESS Millers Island Rd. (Bx. 68B, Rt. 10) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First H. Middle JONES Last PROCASCO (Served as: William H.) 4. DATE OF DEATH Month August Day 18 Year 1960		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 29, 1894 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles Procasco 14. MOTHER'S MAIDEN NAME Rachel Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes WW I 16. SOCIAL SECURITY NO. 213-03-1563 17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. FORT HOWARD DIVISION Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 541.1 DUE TO ACUTE SUPPURANT PERITONITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO PERFORATED PEPTIC ULCER, DUODENUM (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Solitary Cyst, left kidney. Arteriosclerotic Heart Disease.		INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT RECENT	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that X (this hospital) attended the deceased from August 11, 1960 to August 18, 1960 , that X (we) last saw the deceased alive on August 18, 1960 , and that death occurred at 10:45 P. M. from the causes and on the date stated above. 22a. SIGNATURE Frederick S. Donaldson M.D. 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. 22b. DATE SIGNED 8/19/60 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8-22-60 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland 23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook - Blight, Inc., 6009 Harford Road, Balto. 14 25a. REC'D BY REGISTRAR AUG 24 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

8888

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8869
CERTIFICATE OF DEATH
08840

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. LENGTH OF STAY IN 1b <u>74. Howard P.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Haven Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OTTO</u> First <u>KAYES</u> Middle Last		4. DATE OF DEATH <u>Aug. 28</u> Month Day Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Strapman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicodemus Kayer</u>		14. MOTHER'S MAIDEN NAME <u>Heller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Forest Haven Conv. Home Rec.</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO (b) <u>PARTIAL INFESTINAL OBSTRUCTION</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1960</u> to <u>8/22 1960</u> , that (I) (we) last saw the deceased alive on <u>8/28 1960</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>		22d. ADDRESS <u>5800 E. CONNORSON AVE. BALTO. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>8/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Ind</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>MacDuff + Son</u> ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 31 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

8870

CERTIFICATE OF DEATH

08841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 Beaumont Ave.		d. STREET ADDRESS 20 Beaumont Ave.	
3. NAME OF DECEASED (Type or print) First Agnes Middle Lillian Last Kemp		4. DATE OF DEATH Month August Day 23 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Health Nurse-Ret.		10b. KIND OF BUSINESS OR INDUSTRY Balto. City	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Francis S. Kemp		14. MOTHER'S MAIDEN NAME Agnes L. Bffutt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. INFORMANT Address Miss Mary L. Kemp-20 Beaumont Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Atrial Fibrillation (c) Generalized Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 hrs - 10 years - 6 years -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1935 to August 23, 1960 that I last saw the deceased alive on August 10, 1960 , and that death occurred at 9 P M , from the causes and on the date stated above. ACTUAL SIGNATURE Wetherbee Fort M.D. ADDRESS (Street, city or town, state) 6 Sutton Ave. Catonsville, Md DATE SIGNED PHYSICIAN'S NAME (Type) Wetherbee Fort			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-25-60	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home-Catonsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 29 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08841

CERTIFICATE OF DEATH

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THIS IS TO CERTIFY

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>	c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>33 TOWSON 55</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>COCKEYSVILLE RD</u>		d. STREET ADDRESS <u>33 WILLOW AVE, 1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>MATILDA</u> Last <u>KENNEDY</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-89</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>FINLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Frances A. Thomas, Cockeysville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>42001</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 MIN</u> <u>1 MO.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William A. Pillsbury</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/22/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 24, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>		22d. LOCATION (City, town, or county) <u>TOWSON, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>			

1 8872 Item 2 Film 270 9-6-60 et 08843 Reg. Dist. No. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: Attach this certificate and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: Attach this certificate and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER Baltimore 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Convalescent Home		d. STREET ADDRESS 611 S. 46th St. 19 Harrison Ave-20	
3. NAME OF DECEASED (Type or print) Mary A. Kestner		4. DATE OF DEATH Month Aug Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1977
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	
11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ? LLOYD.		14. MOTHER'S MAIDEN NAME UNKNOWN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT ANNA K. MEISENHOLDER		Address 611 S. 46TH ST. BALTO., 24 MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO 250X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sanguine left foot (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 mo 8 mo 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 28, 1958 to Aug 22, 1960 , that I last saw the deceased alive on Aug 15, 1960 , and that death occurred at 1102 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Nicoli M.D.		ADDRESS (Street, city or town, state) 108 S. Taylor Ave DATE SIGNED 8/22/60	
PHYSICIAN'S NAME (Type) JOSEPH NICOLI M.D.		Early 21 Ind.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-25-60.	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Gailer		24a. REC'D BY REGISTRAR DATE AUG 26 '60	
ADDRESS 6224 EASTERN AVE. BALTO., 24, MD.		24b. REGISTRAR'S SIGNATURE William S. Kunk	

CERTIFICATE OF DEATH

Antoine. well known
Baltimore Bellows
Longshore left foot
Coxe...

June 12 1882
John C. [illegible]
108 2 Douglas
June 21 1882

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8797

08844

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1501 S.Rolling Rd				e. STREET ADDRESS 1501 S.Rolling Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Winfield Last Keyes				4. DATE OF DEATH Month Aug. Day 22 Year 1960			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar.3,1890	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician				10b. KIND OF BUSINESS OR INDUSTRY U.S.Gov'T		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert T.Keyes				14. MOTHER'S MAIDEN NAME Margaret-----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Mr.Henry W.Jones,100 Belmore Rd.				Address LUTHERVILLE MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO Myocardial Infarction (c) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH Myocardial Infarction							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 1959 to Aug 22, 1960 , that (I) (we) last saw the deceased alive on Aug 22, 1960 , and that death occurred at 9:05 PM , from the causes and on the date stated above.							
22a. SIGNATURE James P. Chedoke				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/24/60	
22c. PHYSICIAN'S NAME (Type) Chedoke, James P.				22d. ADDRESS Chedoke, James P.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/25/60		23c. NAME OF CEMETERY OR CREMATORY Stone Chapel Cemty.	
23d. LOCATION (City, town, or county) (State) Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun.Dir.4101 Edmondson Ave.				25a. REC'D BY REGISTRAR DATE AUG 26 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

08214

8381



Baltimore

Relay

1901 S. 11th St.

1901 S. 11th St.

Robert T. Hayes

1901 S. 11th St.

Robert T. Hayes

Robert T. Hayes

1901 S. 11th St.

Handwritten: Department of the Interior
Bureau of Land Management
Washington, D. C.



Handwritten: Approved by the Secretary of the Interior
on 11/22/00
1901 S. 11th St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 18 Film 269 8-26-60 500 8873 Item 1 Film 269 8-24-60 et 08845											
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>2001-4</u>							
c. LENGTH OF STAY IN 1b <u>1Y 3M 10D</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove St. Hosp.</u>				d. STREET ADDRESS <u>2231 Annapolis Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Herman Keyser</u>				4. DATE OF DEATH <u>8 17 1960</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-1891</u>		9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Keyser</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hitt</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-09-1085</u>		17. INFORMANT <u>Records Spring Grove Hospital</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>C.B.S anoxia to cerebral arteriosclerosis</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> (c) <u>CVD c HTB with hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>57</u> , to <u>Aug. 17</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug. 17</u> , 19 <u>60</u> , and that death occurred <u>11 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Stella Wachslar</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>8-18-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M.D.</u>				22d. ADDRESS <u>Spring Grove State Hosp. Catonsville 28, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8-20-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Run</u>		23d. LOCATION (City, town, or county) (State) <u>Wash Blad</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Louison</u>				ADDRESS <u>2359 Wash Blad Rd</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 19 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

08847

CERTIFICATE OF DEATH

88473

1. Name of deceased: *James K. Jones*
2. Sex: *Male*
3. Age: *35*
4. Date of birth: *Jan 15, 1900*
5. Place of birth: *St. Louis, Mo.*
6. Date of death: *Jan 15, 1935*
7. Place of death: *St. Louis, Mo.*
8. Cause of death: *Heart Disease*
9. Duration of illness: *3 months*
10. Name of physician: *Dr. J. H. Smith*
11. Name of funeral director: *Mr. W. B. Brown*
12. Name of informant: *Mr. J. K. Jones*
13. Address of informant: *1234 Main St., St. Louis, Mo.*
14. Signature of informant: *[Signature]*
15. Signature of physician: *[Signature]*
16. Signature of funeral director: *[Signature]*
17. Signature of informant: *[Signature]*
18. Signature of informant: *[Signature]*
19. Signature of informant: *[Signature]*
20. Signature of informant: *[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8874
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08846

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3V 01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mercy Villa</u>		d. STREET ADDRESS <u>1316 E. 36th St.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCES (FANNY) W. KINLEIN</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 9, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE & BORN PARTNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLISHING</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>JOSEPH WILLS</u>		14. MOTHER'S MAIDEN NAME <u>JANE THORNE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-3699</u>	
17. INFORMANT <u>SON</u>		Address <u>ARTHUR KINLEIN 612 REGESTER AVE-12</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420-1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE ?</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUN 1, 1960</u> , to <u>AUG 1, 1960</u> , that (I) (we) last saw the deceased alive on <u>JULY 31, 1960</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Fredrick J. Vollmer</u>		22b. DATE <u>AUG 1, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u>		22d. ADDRESS <u>6100 YORK RD. BALTO-12 MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG 3, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. VENKUS & SONS CO</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>	
ADDRESS <u>4905 YORK ROAD BALT 12, MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

1000 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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4
8875
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08847

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 29yr3mth16dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Sophia Last Kintop		4. DATE OF DEATH Month August Day 21 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1895
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 2 Days 12 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John strobel		14. MOTHER'S MAIDEN NAME Sophia Grapper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4-22-2 IMMEDIATE CAUSE (a) Myocardial Degeneration & Failure DUE TO 287X (b) Essential Hypertension Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (c) Obesity			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 1/2 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 23, 1960 to August 21, 1960 , that (I) (we) last saw the deceased alive on August 21, 1960 , and that death occurred at 11:39 M. from the causes and on the date stated above.			
22a. SIGNATURE Gertrude J. Fleischmann		22b. DATE SIGNED Aug 21 1960	
22c. PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 8/24/60	
23c. NAME OF CEMETERY OR CREMATORY Moreland Park		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		25a. REC'D BY REGISTRAR DATE AUG 24 '60	
ADDRESS 5305 Bayford		25b. REGISTRAR'S SIGNATURE Charles S. Grant	

1944

CERTIFICATE OF CLAIM

8047

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8876

CERTIFICATE OF DEATH

08848

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradshaw Rd.</u>		d. STREET ADDRESS <u>Bradshaw Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Louis</u> Middle <u>Koppleman</u> Last		4. DATE OF DEATH <u>Aug</u> Month <u>9</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Koppelman</u>		14. MOTHER'S MAIDEN NAME <u>Anna Schaub</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-8313</u>	
17. INFORMANT <u>Mrs. Emma Koppelman</u>		Address <u>Bradshaw, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>3 yr.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Aug.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug. 8</u> , 19 <u>60</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>8-9-60</u>	
PHYSICIAN'S NAME (Type) <u>Wm. A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-13-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cassady Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	24a. REC'D BY REGISTRAR <u>AUG 12 '60</u> DATE
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8877

CERTIFICATE OF DEATH

08849

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>			c. LENGTH OF STAY IN lb <u>4 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1830 Gough Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADAM</u> Middle <u>S.</u> Last <u>KOZLOWSKI</u>				4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 29, 1913</u>	
9. AGE (In years lost birthday) yrs. <u>46</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		11. BIRTHPLACE (State or foreign country) <u>Biloxi, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Kozlowski</u>				14. MOTHER'S MAIDEN NAME <u>Wanda Somuk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-05-4114</u>		17. INFORMANT <u>ClinRecords, VAH, Balto. Md. Ft Howard Division</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC DILATATION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>RHEUMATIC HEART DISEASE WITH</u> <u>MITRAL INSUFFICIENCY AND AORTIC STENOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(c) CONGESTIVE HEART FAILURE</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 7, 1960</u> , to <u>August 11, 1960</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 11, 1960</u> , and that death occurred <u>4:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Lawrence D. Marcus</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE D. MARCUS, M.D.</u>				22d. ADDRESS <u>VAH, BALTO. MD. FT HOWARD DIVISION</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-16-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm-Cook Blight Funeral Home, 6009 Harford Rd.</u>				25a. REC'D BY REGISTRAR <u>Balto. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01220

U.S. DEPARTMENT OF HEALTH

2011



8878

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE		c. LENGTH OF STAY IN 1b 22 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 805 RoseDAle Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stanley Middle John Last Kozlowski		4. DATE OF DEATH Month Aug. Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1913
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	11. BIRTHPLACE (State or foreign country) Boston, MASS.
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME John	
14. MOTHER'S MAIDEN NAME Mary		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. None		17. INFORMANT Name Helene D. Kozlowski Address 805 RoseDAle Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardio-Vascular disease DUE TO (c) 3-yes			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1910 to Aug 29, 1960 that I last saw the deceased alive on Aug 28, 1960 and that death occurred at 10 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 8/31/60			
ACTUAL SIGNATURE Philip E. Coach		PHYSICIAN'S NAME (Type) Baltimore Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 2, 1960	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Coach		ADDRESS 1211 Chesaco Ave.	
24a. REC'D BY REGISTRAR DATE SEP 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Billings

General

April 18, 1913

General

1

John D. Mackay

Secretary

General

General

General

General

General

General

General

General

General

8879

CERTIFICATE OF DEATH

08851
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7516 Hillsway</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Eva P. Kramer</i>		4. DATE OF DEATH <i>August 8th 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-1897</i>
9. AGE (In years lost birthday) <i>62</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>floor lady</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Petza</i>		14. MOTHER'S MAIDEN NAME <i>Mary Arka</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>INFORMANT Mrs Rita J. Wallace</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>175.0</i> DUE TO <i>Carcinoma of ovary with generalized metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr 3?</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/26/1959</i> to <i>8/8/1960</i> , that I last saw the deceased alive on <i>8/6/1960</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Marion Friedman</i> M.D.		DATE SIGNED <i>8/8/60</i>	
PHYSICIAN'S NAME (Type) <i>MARION FRIEDMAN</i>		ADDRESS (Street, city or town, state) <i>5211 Harford Road Baltimore, 14, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/12/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 9 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1586

15220

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8880

CERTIFICATE OF DEATH

08852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3319 Essex Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MOLLIE Middle SIEGEL Last KRETZER		4. DATE OF DEATH Month August 19 Day 19 Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Shop	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gottlieb Siegel		14. MOTHER'S MAIDEN NAME Bertha ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Bertha Tuttleman 3319 Essex Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Brain 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) None			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 59 , to 8/18 , 19 60 , that I last saw the deceased alive on 8/18 , 19 60 , and that death occurred at 3:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Elliot R. Fisher M.D. 330 W. Pratt St PHYSICIAN'S NAME (Type) Elliot R. Fisher D.A. & T.O. (M.D.)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8/20/60	22c. NAME OF CEMETERY OR CREMATORY Baron-Hirsch Cemetery	22d. LOCATION (City, town, or county) Staten Island, New York
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. Inc. 6010 Reisterstown Rd. Baltimore 15, Md.		24a. REC'D BY REGISTRAR DATE AUG 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The original may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

108752

8880

CERTIFICATE OF DEATH

MADE IN THE CITY OF NEW YORK



Birthplace

Residence

Notes in the Death Register Book

1917 Census No.

Married

Single

Widow

Female

Male

Age

Time of Death

Place

Cause

Occupation

John A. Elmer

Residence

1917 Census No.

Mr. George T. Elmer

1917 Census No.

United States, New York

1917 Census No.

1917 Census No.

1917 Census No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8881

CERTIFICATE OF DEATH

08853

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MIDDLE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home				d. STREET ADDRESS 2627 Maryland Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lula Middle G. Last Kuhlemann				4. DATE OF DEATH Month Aug. Day 27 Year 19 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22 1979		9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles F.				14. MOTHER'S MAIDEN NAME Mary Schultheis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-3187A		INFORMANT Address Records 6811 Campfield Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO (b) Angino Pectoris DUE TO (c) Acute Cardiac Failure with Pulmonary Odema						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 yrs. 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1960 , to Aug. 28, 1960 , that I last saw the deceased alive on Aug. 27, 1960 , and that death occurred at 10.15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4108 Liberty Hgts Ave 8/28/60							
ACTUAL SIGNATURE Earl L. Chambers		M.D. 4108 Liberty Hgts Ave.					
PHYSICIAN'S NAME (Type) Earl L. Chambers		4108 Liberty Hgts Ave.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/60		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Villetville		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. A. Heemann				ADDRESS 6067 Harford Rd.		24a. REC'D BY REGISTRAR DATE SEP 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-27-58

CERTIFICATE OF DEATH

8881

Baltimore

Johnston

Alphonsus John

Male

White

Age 71

Aug 22 1958

Baltimore, Md.

Residence

Birth

Harry Johnston

Charles F.

333-10-1111

Johnston, Harry

Johnston, Harry

Johnston, Harry

Johnston, Harry

Johnston, Harry

Johnston, Harry

Johnston, Harry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 20			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Baltimore 20				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1537 ALBENEY					d. STREET ADDRESS 1537 ALBENEY			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last STEPHEN LARICHIUTA					4. DATE OF DEATH Month Day Year AUG 2ND 1960				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 7-1960		9. AGE (In years last birthday) yrs. 6 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY —			11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ALBERT LARICHIUTA					14. MOTHER'S MAIDEN NAME JOAN MOORE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —			16. SOCIAL SECURITY NO. —		17. INFORMANT Address PARENTS - SAME AS ABOVE				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3444X DUE TO Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1960, to 8-2, 1960 that (I) (we) last saw the deceased alive on 8-2, 1960 and that death occurred at 11 M. from the causes and on the date stated above.									
22a. SIGNATURE Marvin Bromberg M.D.					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) MARVIN BROMBERG		
22d. ADDRESS 805 Fursberg Ave									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
Burial			Aug 4-1960		Sacred Heart Cem.		German Hill Rd. Md		
24. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly					25a. REC'D BY REGISTRAR AUG 5 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		
25c. ADDRESS 418 Eastern Blvd Balto. Md									

2046274XV3

028250

CERTIFICATE OF DEATH

8882



NAME: WHITE
AGE: 62
SEX: M
DATE OF BIRTH: 1900
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE: [illegible]

[Faint, mostly illegible text at the bottom of the page, possibly a continuation of the certificate or a separate document.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8883 CERTIFICATE OF DEATH

Reg. Dist. No. 8855

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Ferguson Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Elizabeth Laudenklos</u>		4. DATE OF DEATH Month Day Year <u>August 26, 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Reichart</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Schroeder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles Laudenklos</u>		Address <u>Ferguson Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral & generalized arteriosclerosis</u> DUE TO (c) <u>20 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cardiac vascular disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>N.Y.</u> , 19 <u>54</u> , to <u>Aug.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 5, 19 60</u> , and that death occurred at <u>5:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert Harris</u> M.D.		ADDRESS (Street, city or town, state) <u>8120 Harford Rd., Balto. Md.</u>	
PHYSICIAN'S NAME (Type)		DATE <u>8/22/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-30-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Sullivan 7401 Deland</u>		24a. REC'D BY REGISTRAR <u>AUG 31 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Charles S. Knap</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1925

RECEIVED - TEXAS DEPT. OF AGRICULTURE

8884

[Faint, mostly illegible text, likely a letter or report, spanning the main body of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8884

CERTIFICATE OF DEATH

08856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home 812 Regester Avenue				d. STREET ADDRESS 546 Hampton Lane			
3. NAME OF DECEASED (Type or print) Dr. Granville A. Lawrence				4. DATE OF DEATH August 8 1960			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1883		9. AGE (In years and birthday) 76 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY Philadelphia, Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas A. Lawrence				14. MOTHER'S MAIDEN NAME Mary E. Watson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. M. E. Whitney, 546 Hampton Lane, Towson 4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4:20 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of vocal cord; treated; no metastases grossly							INTERVAL BETWEEN ONSET AND DEATH 3 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from never , 19____, to____, 19____, that I last saw the deceased alive on____, 19____, and that death occurred at____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 E Chase St. DATE SIGNED 8/9/60 ACTUAL SIGNATURE W B Daniels, Jr. M.D. 11 E Chase St. PHYSICIAN'S NAME (Type) Worth B. Daniels, Jr., M. D. 11 East Chase Street Baltimore 2, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8-10-60		22c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery		22d. LOCATION (City, town, or county) (State) Roslyn, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR AUG 10 '60		24b. REGISTRAR'S SIGNATURE Chas. E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

: 522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8885

CERTIFICATE OF DEATH

Reg. Dist. No. 08857

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>3001.4</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Lines</i>		d. STREET ADDRESS <i>2625 Quantico Ave</i>	
3. NAME OF DECEASED (Type or print) <i>GOLDIE - LEVIN</i>		4. DATE OF DEATH <i>8-5-1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>67</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
13. FATHER'S NAME <i>Lazer</i>		14. MOTHER'S MAIDEN NAME <i>Anna</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Leonard Levin - son</i>	
18. CAUSE OF DEATH [Enter only one cause per line, of (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>350X</i> DUE TO <i>Acute Pyelonephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Paralysis agitans</i> DUE TO <i>Generalized arteriosclerosis</i> (c) <i>Metastatic Ovarian Carcinoma 14 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2d</i> <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 19 <i>59</i> , to <i>August 60</i> , that I last saw the deceased alive on <i>Aug. 3</i> , 19 <i>60</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Daniel Likel</i>		ADDRESS (Street, city or town, state) <i>3600 Lochearn Dr</i>	
PHYSICIAN'S NAME (Type) <i>Baltimore Md</i>		DATE SIGNED <i>5 Aug. 60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-7-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>United Hebrew</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		ADDRESS <i>2100 Eutaw Place</i>	
24a. REC'D BY REGISTRAR <i>AUG 8 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	

1923



1923

[Faint, mostly illegible handwritten text follows, likely containing details of the death certificate.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
88886
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08858

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6400 Bellona Ave.</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mercy Villa</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>	
f. STREET ADDRESS <u>6400 Bellona Avenue</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cassandra A. Lochary</u>		4. DATE OF DEATH Month Day Year <u>August 27, 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/71</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Lochary</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John P. Dochary</u>		Address <u>Balto. 6118 Alta Ave. #6, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC Cardiovascular Disease</u> 422.1 DUE TO (b) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Interval BETWEEN ONSET AND DEATH</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> 19 <u>50</u> to <u>8/27/60</u> 19 <u>60</u> , that (I) <u>last</u> saw the deceased alive on <u>8/26/60</u> 19 <u>60</u> , and that death occurred at <u>6:05 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John R. Davis</u>		22b. DATE SIGNED <u>8/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Davis, M. D.</u>		22d. ADDRESS <u>401-402 Medical Arts Bldg., Balto., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius</u>		23d. LOCATION (City, town, or county) (State) <u>Bel Air (Rural) Harford, County</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fritz</u>		25a. REC'D BY REGISTRAR <u>W. Broadway & Williams St. BEL Air, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. DATE <u>AUG 31 60</u>	

17722

CERTIFICATE OF DEATH

8888



[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Registrar" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08859

8887

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTPOINT		c. LENGTH OF STAY IN 1b EASTPOINT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7814 WYNN BROOK		d. STREET ADDRESS 7814 WYNN BROOK 1	
3. NAME OF DECEASED (Type or print) HASSIE First LOWE Middle Last		4. DATE OF DEATH Month AUG. Day 5 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV - 28 - 1904
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM I. LOWE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT LANDY LOWE - SAME AS ABOVE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC-CARDIO-VASCULAR 432.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DISEASE (c) DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8-6-1960	
22c. NAME OF CEMETERY OR CREMATORY PIKEVILLE, KENTUCKY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly - 418 Eastern Ave (Bldg 2)		24a. REC'D BY REGISTRAR DATE AUG 16 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

91 5920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8888

CERTIFICATE OF DEATH

Reg. Dist. No.

08860

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph's Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle LUCZKOWSKI Last LUCZKOWSKI				4. DATE OF DEATH Month August Day 6, Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 4 Hours 1 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Lawrence Kozlowski				14. MOTHER'S MAIDEN NAME Victoria Jablonska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Joseph Luczkowski, 1005 S. East Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Several Arteriosclerosis 450.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Aug. 4, 1960 , to Aug. 6, 1960 , that I last saw the deceased alive on Aug. 4, 1960 , and that death occurred at 11 a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. J. Schmitz				ADDRESS (Street, city or town, state) 701 N. Karwood Ave., Baltimore, Maryland			
PHYSICIAN'S NAME (Type) Wm. J. Schmitz				DATE SIGNED 8/8/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/60		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City or town or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE M. F. SADOWSKI & SONS, 1808 EASTERN AVENUE				24a. REC'D BY REGISTRAR DATE AUG 9 '60		24b. REGISTRAR'S SIGNATURE Clara S. Kram	

CERTIFICATE OF DEATH

1933

1000

1000

<p>1. NAME OF DECEASED JAMES H. HARRIS</p>		<p>2. SEX Male</p>	
<p>3. AGE 68 years</p>		<p>4. DATE OF BIRTH 1865</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Clerk</p>	
<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF MARRIAGE 1900</p>	
<p>9. NAME OF SPOUSE Mary H. Harris</p>		<p>10. DATE OF DEATH 1933</p>	
<p>11. PLACE OF DEATH Baltimore, Md.</p>		<p>12. CAUSE OF DEATH Heart Disease</p>	
<p>13. MEDICAL HISTORY Hypertension</p>		<p>14. SIGNATURE OF PHYSICIAN J. H. Harris</p>	
<p>15. SIGNATURE OF WITNESS J. H. Harris</p>		<p>16. SIGNATURE OF DECEASED J. H. Harris</p>	

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

88889

08861

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>				c. LENGTH OF STAY IN 1b <u>54 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1607 McCulloh Street</u>			
3. NAME OF DECEASED (Type or print) Served as: (First Samuel V. Makell) Last SAMUEL V. MACKALL				4. DATE OF DEATH Month August Day 14 Year 1960			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 17, 1889</u>	
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James S. Mackall</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> WW I				16. SOCIAL SECURITY NO. <u>215-09-6866</u>		17. INFORMANT <u>Clin. Recored, VAH, Baltimore 18, Md. Ft. Howard Div.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF STOMACH</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>June 21, 1960</u> , to <u>August 14, 1960</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>August 14, 1960</u> , and that death occurred at <u>10:45 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frederick S. Donaldson MD</u>				22b. DATE <u>8/15/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. DONALDSON, M.D.</u>				22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-18-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter, 3035 W. North Ave. Balto. Md.</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. Kraus</u>	

CERTIFICATE OF DEATH

8-1-19

1919

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8890

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08862

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3Y01-4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (2)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 623 Saint Paul Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle H. Last McFARLAND				4. DATE OF DEATH Month August Day 18 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 22, 1895		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Erection Engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Atlanta, Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward H. McFarland				14. MOTHER'S MAIDEN NAME Agnes Ferrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 257-05-1158		17. INFORMANT Address Clin. Rec. VAH, Baltimore 18, Md. FORT HOWARD DIV.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 420.0 PULMONARY CONGESTION AND EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) EMPHYSEMA, BILATERAL, MARKED						INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cortical Adenomata, adrenals, bilateral. Cerebral Congestion.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 15, 1960 to August 18, 1960 , that (I) (we) last saw the deceased alive on August 18, 1960 , and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick S. Donaldson</i>				22b. DATE 8/19/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-22-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				25a. REC'D BY REGISTRAR AUG 24 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 1 or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8891

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08863

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN lb 121 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (2)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 924 East Lombard Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle ---- Last MC LAIN				4. DATE OF DEATH Month August Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1923	
9. AGE (In years lost birthday) 37 yrs.		10. AGE (In years lost birthday) 37 yrs.		11. BIRTHPLACE (State or foreign country) Dillon, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aide (Nurses)				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Dillon, S. Carolina	
13. FATHER'S NAME William McLain				14. MOTHER'S MAIDEN NAME Catherine M. Barr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 247-28-9370		17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FT. HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 METASTATIC CARCINOMA, RIGHT FRONTAL LOBE OF BRAIN AND RIGHT ADRENAL. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA (Clinical - Cured) DUE TO (c) UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Pulmonary Congestion and Edema, recent (b) 2. Pulmonary Emphysema, old.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 29, 1960 to August 28, 1960 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on August 28, 1960 , and that death occurred at PM 9:25 M, from the causes and on the date stated above.							
22a. SIGNATURE Frederick S. Donaldson MD				22b. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION		22c. DATE SIGNED 8/29/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. 17,				25a. REC'D BY REGISTRAR DATE SEP 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krand	



RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.
JAN 10 1964
MEMORANDUM
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of text that are extremely faint and largely illegible due to the quality of the scan. The text appears to be a standard memorandum format with a subject line, followed by several paragraphs of body text.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8892

CERTIFICATE OF DEATH

Reg. Dist. No. 08864

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence, before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Baltimore</u>		c. LENGTH OF STAY IN 1b <u>20 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Key Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond M. Miller</u>		4. DATE OF DEATH <u>Aug 19</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1899</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fabricating Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Monkton, Md. R.D. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>S. Howard Miller</u>		14. MOTHER'S MAIDEN NAME <u>Tempie Mays</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>206-01-2388</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> 19 <u>60</u> to <u>Aug 19</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Aug 1</u> 19 <u>60</u> , and that death occurred at <u>8:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		DATE SIGNED <u>8/19/60</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 22, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fosters Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md. R.D.</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>Joseph Fortensterling, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>Aug 23 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/22/21

OFFICE OF THE SECRETARY OF THE ARMY

11/22/21

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report.]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8893

CERTIFICATE OF DEATH

Reg. Dist. No. 08865

1. PLACE OF DEATH o. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home		d. STREET ADDRESS 5307 Barbara Avenue	
3. NAME OF DECEASED (Type or print) First Eliza Middle M. Last Mitchell		4. DATE OF DEATH Month August Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1875
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Covell		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Duncan Miller, 4511 Mainfield Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350X DUE TO ARTERIO-SCLEROTIC CHANGES - UNUSUAL DISORDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MARKIN SANITARY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/4 , 19 60 , to 8/5 , 19 60 , that I last saw the deceased alive on 8/4 , 19 60 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5500 EDWARDS AVE BALTIMORE, MD DATE SIGNED 8/6/60			
ACTUAL SIGNATURE John H. Shaw M.D.		PHYSICIAN'S NAME (Type) John H. Shaw MD	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	22b. DATE THEREOF 8-8-60	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, 6009 Harford Road		24a. REC'D BY REGISTRAR DATE AUG 8 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(continued)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08866

8894

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 SANFORD AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NELLIE B. MURPHY</u>		4. DATE OF DEATH <u>AUG. 3, 1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 24/1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>JAMIES S. BENSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE ALLNUTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>MR. HARRY T. MURPHY</u> Address <u>6207 Hooks Lane, BALTO. 27, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>GENERALIZED</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA</u> <u>STOMACH</u> DUE TO (c) <u>1 1/2 YR.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 YR.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>this oked by Med. Examiner</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>duphane 8/5/60-11.55 AM.</u>	20f. (City or town) (County) (State) <u>MD.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1940</u> to <u>Aug. 3, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 29, 1960</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. H. CROWTHER</u> <u>JOHN F. SCHAEFER</u>		22b. DATE SIGNED <u>8/5/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>John F. Schaefer MD</u>		22d. ADDRESS <u>401 RANDOM ROAD - 29</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	23d. LOCATION (City, town, or county) (State) <u>FREDERICK, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUN. DIR. 4101 EDMONDSON</u>		25a. REC'D BY REGISTRAR <u>AUG 8 '60</u>	
ADDRESS <u>AVE</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

AP

STATE OF TEXAS

8888

(M)

(T)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8895

CERTIFICATE OF DEATH

08867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b 6 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1330 Seling Avenue		e. STREET ADDRESS 1330 SELING AVENUE	
3. NAME OF DECEASED (Type or print) DAVID W. NARANGO SR.		4. DATE OF DEATH Month AUGUST Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Cuba		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Antonio Narango		14. MOTHER'S MAIDEN NAME Anita Mandosa	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Marie Narango		Address 1330 Seling Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma sigmoid 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 104 W. Madison St.		(County) (State)	
21. I certify that I attended the deceased from 15 Sept. 1959 to 3 Aug. 1960 , that I last saw the deceased alive on 3rd Aug. 1960 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S.E. Proctor		ADDRESS (Street, city or town, state) DATE SIGNED 104 W. Madison St. Aug. 3. 60	
PHYSICIAN'S NAME (Type) S. E. Proctor			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/6/60	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC.		ADDRESS BALTIMORE MD.	
24a. REC'D BY REGISTRAR AUG 4 60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

8885

DECEASED NAME JAMES EARL RAY		SEX MALE		AGE 35	
BIRTH DATE JAN 5 1928		PLACE MOBILE, ALABAMA		RACE WHITE	
OCCUPATION MEMBER OF CONGRESS		RESIDENCE 1000 BROADWAY, NEW YORK, N.Y.		DECEASED AT 1000 BROADWAY, NEW YORK, N.Y.	
DATE OF DEATH APR 4 1968		TIME OF DEATH 11:57 AM		PLACE OF DEATH NEW YORK, N.Y.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH SUICIDE		MEDICAL EXAMINER JAMES EARL RAY	
SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF WITNESS JAMES EARL RAY		SIGNATURE OF PHYSICIAN JAMES EARL RAY	
SIGNATURE OF CORONER JAMES EARL RAY		SIGNATURE OF JURY JAMES EARL RAY		SIGNATURE OF JUDGE JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8896

08868

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Maryland Avenue				d. STREET ADDRESS 9 Maryland Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CLARENCE Middle EMORY Last NETHKEN				4. DATE OF DEATH Month August Day 14 , Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1909	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 19		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Con. Can Co.		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Steward B. Nethken				14. MOTHER'S MAIDEN NAME Addie Fuhrman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II		17. INFORMANT Mrs. Helen Nethken, 9 Maryland Ave., Towson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenocarcinoma, rt. lung, & cerebral metastasis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 10 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Apr. 29, 1960 to August 14, 1960 , that (I) (we) last saw the deceased alive on Aug. 13, 1960 , and that death occurred at 2:25 AM, from the causes and on the date stated above.							
22a. SIGNATURE Roy W. Chesnut, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Roy W. Chesnut, Jr., M. D.				22d. ADDRESS 25 W. Pennsylvania Ave., Towson 4, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 17, 1960		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 19 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

08888

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
CERTIFICATE OF DEATH

8888

1. Name of deceased	2. Date of death	3. Place of death	4. Cause of death
John James, son, Toronto, Maryland	Jan. 17, 1960	Woodlawn Cemetery, Woodlawn, D.C.	Heart failure
5. Date of birth	6. Sex	7. Race	8. Marital status
Sept. 25, 1900	Male	White	Married
9. Date of death	10. Place of death	11. Cause of death	12. Signature of physician
Jan. 17, 1960	Woodlawn Cemetery, Woodlawn, D.C.	Heart failure	Dr. J. H. Smith

13. Date of death

14. Place of death

15. Cause of death

16. Signature of physician

17. Date of death

18. Place of death

19. Cause of death

20. Signature of physician

Reg. Dist. No. 08869

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		d. STREET ADDRESS 6507 Kenwood Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6507 Kenwood Avenue #6						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARBARA		First BARBARA		Middle NOREK		Last NOREK	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1881	
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benes		14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Jerry W. Norek, son, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION & MYOCARDIAL INFARCT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC C.V. DISEASE & DUE TO (c) HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 420.1 4/6/60 SEPT 1 1958					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DEATH OF DECEASED		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a. m. NONE 19 p. m. NONE		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> NONE		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State) NONE	
21. I certify that I attended the deceased from 9-1-59 to 8-4-60 , that I last saw the deceased alive on 8-4-60 , 19 60 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 842 S. EAST AVE BALTO. 24 MD.		DATE SIGNED 8-5-60			
ACTUAL SIGNATURE E. A. SCHIMUNEK		M.D. E. A. SCHIMUNEK M.D.					
PHYSICIAN'S NAME (Type) E. A. SCHIMUNEK M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/8/60		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc.		ADDRESS 2001-3-5 E. Madison St.		24a. REC'D BY REGISTRAR DATE AUG 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the [redacted] or attending physician.

TO FUNERAL DIRECTOR: As this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 1, 1961	
PLACE OF DEATH		AGE	
HARRIS HOME, 1234 E. BALTIMORE AVE.		65	
DATE OF BIRTH		SEX	
JANUARY 1, 1896		MALE	
PLACE OF BIRTH		RACE	
BALTIMORE, MD		WHITE	
DATE OF DEATH		TIME OF DEATH	
JANUARY 1, 1961		10:00 AM	
PLACE OF DEATH		CAUSE OF DEATH	
HARRIS HOME, 1234 E. BALTIMORE AVE.		HEART DISEASE	
DATE OF BIRTH		SEX	
JANUARY 1, 1896		MALE	
PLACE OF BIRTH		RACE	
BALTIMORE, MD		WHITE	
DATE OF DEATH		TIME OF DEATH	
JANUARY 1, 1961		10:00 AM	
PLACE OF DEATH		CAUSE OF DEATH	
HARRIS HOME, 1234 E. BALTIMORE AVE.		HEART DISEASE	

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8898 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08870									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 510 Stony bottom Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingsville d. STREET ADDRESS 510 Stonybottom Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MELVIN GEORGE OREM					4. DATE OF DEATH Month 8/8/ Day 19 Year 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1904		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME George N. Orem					14. MOTHER'S MAIDEN NAME Amsey Ellen				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 212-05-5972				
17. INFORMANT Mrs. Elsie Folks					Address 510 Stoney Batter Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest DUE TO (b) 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound of chest				
20c. TIME OF INJURY Month, Day, Year A.M. 8/8/ 19 60		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) outside home		2Df. (City or town) (County) (State) Kingsville, Baltimore, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Peter Rieckert EXAMINER'S NAME (Type) Peter Rieckert, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/8/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-1960		22c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		22d. LOCATION (City, town, or country) (State) Belair, Md.			
23. FUNERAL DIRECTOR Lassahn Funeral Home					24a. REC'D BY REGISTRAR 7401 Belair Road		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

02340

8888



Guest room of guest

X outside home

X

Hotel Hickory, N.C.

8/1/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8899

CERTIFICATE OF DEATH

08871

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>Aged Men + Aged Women Home</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Md</u> COUNTY <u>Baltimore</u>	
a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
b. LENGTH OF STAY IN lb <u>1 yr. 1 mo</u>		d. STREET ADDRESS <u>1802 Walbrook Ave.</u> <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>615 Chestnut Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Fannie</u> Last <u>Paca</u>		4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>9</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co - Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Kuelhinger</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Burk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Aged Men's & Aged Women's Home, Towson 4, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Bronchial</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , to <u>August 15, 1960</u> , that I last saw the deceased alive on <u>August 13, 1960</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland Edward Day</u>		DATE SIGNED <u>August 15, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Newland Edward Day M.D.</u>		ADDRESS (Street, city or town, state) <u>4-2-33rd St - Balto 18 Md</u>	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Christian Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Belair, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

Bp

1883

CERTIFICATE OF DEATH

1883



1883

NEWARK

none

Age of dec'd at death 7 years, 7 months, 1 day

1802 wallbrook

Wm. L. Look, Inc., 1515 E. Paul Street, Baltimore, Md.

Wm. L. Look, Inc., 1515 E. Paul Street, Baltimore, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8900

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08872

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>402 Washington Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Parkin</u> Last <u>Parkin</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1867</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Emile</u>		14. MOTHER'S MAIDEN NAME <u>Sara</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u>Sub-Trochanter fracture left from accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right femur was pinned at the University Hospital on 6-30-60</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>On 6-27-60 patient fell to floor and sustained an intertrochanteric frac. of rt.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>12:45</u> p. m. <u>6-27 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) (County) (State) <u>Catonsville 28, Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		DATE SIGNED <u>Aug. 4, 60</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 6, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wilkes-Barre, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8901

CERTIFICATE OF DEATH

08873

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>1816 Pennsylvania Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E.</u> Last <u>PENDLETON</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 24, 1908</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Road Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Charleston, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Pendleton</u>		14. MOTHER'S MAIDEN NAME <u>Mary (Maiden Name Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>199-05-9564</u>	
17. INFORMANT <u>Clinical Records, Vet. Adm. Hosp./Ft. Howard Div.</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO <u>BRONCHOGENIC CARCINOMA, RIGHT LUNG</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. <u>ENCEPHALOMALACIA, RIGHT CEREBRUM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u> <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 12, 1960</u> to <u>August 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>August 15, 1960</u> , and that death occurred at <u>P. M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>FREDERICK S. DONALDSON, M.D.</u>		22b. DATE SIGNED <u>8/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. DONALDSON, M.D.</u>		22d. ADDRESS <u>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/18/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips, 1808 N. Monroe St., Balto. 17</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

00000



CERTIFICATE OF MARRIAGE

8000



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8902

CERTIFICATE OF DEATH

Reg. Dist. No. 08874

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Carmel Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>W. (Russell) Peregoy</u>		4. DATE OF DEATH <u>August 21</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19 1920</u> <u>Pa.</u>
9. AGE <u>40</u> yrs. last birthday		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Peregoy</u>		14. MOTHER'S MAIDEN NAME <u>Laura Zencker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-0696</u> INFORMANT <u>Mrs. Josephine Peregoy, Parkton, Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO (b) <u>Myocardial stenosis</u> DUE TO (c) <u>Rheumatic heart disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>60</u> , to <u>August 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 20</u> , 19 <u>60</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Herbert Mueller Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>YORK RD. HEREFORD-PARKTON, PA.</u> DATE SIGNED <u>8-22-60</u>	
PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER, JR.</u>		<u>PARKTON MD.</u> <u>8-22-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 24 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Antunietem, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>AUG 25 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Trilene S. Hunt</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

102274

CERTIFICATE OF DEATH

8003

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be a medical or legal record.]

1

08875

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1004 Frances Ave.</u>		d. STREET ADDRESS <u>11004 Frances Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine B. Plaff</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1884</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Kaufmann</u>		14. MOTHER'S MAIDEN NAME <u>Katie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT <u>Wm. L. Plaff, 1004 Frances Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast Metastatic</u> DUE TO (b) <u>Carcinoma of Rt. Breast</u> DUE TO (c) <u>7 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic carcinoma to spine</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 8</u> 19 <u>59</u> to <u>Aug 18</u> 19 <u>60</u> , that (I) (we) lost saw the deceased alive on <u>Aug 17</u> 19 <u>60</u> , and that death occurred at <u>4:15 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>A. Bradley Sanghavi</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-18-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. 4101 Edmonson Ave</u>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug. 22 60</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	
23d. LOCATION (City, town, or county)		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 22 '60</u>		25b. REGISTRAR'S SIGNATURE	

25280

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8903
CERTIFICATE OF DEATH

08876

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
c. LENGTH OF STAY IN 1b 125 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 400 South Macon Street (24)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SOTIRIOS Middle --- Last PLAKITSIS		4. DATE OF DEATH Month August Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15, 1890
9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min. 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Plakitsis		14. MOTHER'S MAIDEN NAME Katherine Pavouris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-36-1034	
17. INFORMANT WW I		Address Clin. Rec., Vet. Adm. Hospital, Balto. Md. Ft. Howard/	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH WIDESPREAD METASTASES DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 162.1 DUE TO (c) 162.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC LYMPHATIC LEUKEMIA INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from March 30, 1960 to August 2, 1960 , that X (we) last saw the deceased alive on Aug. 2, 1960 , and that death occurred at 10:45 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Walter J. Pijanowski		22b. DATE SIGNED 8/3/60	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 6 - 1960	
23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		25a. REC'D BY REGISTRAR AUG 5 '60	
ADDRESS 3500 Bank St., Balto. Md.		25b. REGISTRAR'S SIGNATURE Arthur L. ...	

08830

CERTIFICATE OF BIRTH

08830

Blank form with faint text and lines for data entry.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

8904

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G269 8-29-60 et

08877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 1/2 Parks Avenue				d. STREET ADDRESS 6 Parks Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last MAHLON MCKINLEY POE				4. DATE OF DEATH Month Day Year August 17, 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1904	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quarryman- retired		10b. KIND OF BUSINESS OR INDUSTRY H.T. Campbell Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Clarence Poe				14. MOTHER'S MAIDEN NAME Emma Jane Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-07-5616		17. INFORMANT Address Mrs. Mahlon M. Poe, Cockeysville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Sudden DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio- DUE TO (c) Renal Vascular Disease 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles H. Dorell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20, 1960		22c. NAME OF CEMETERY OR CREMATORY May's Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Timonium, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John Burns' Sons, Towson, Maryland				24a. REC'D BY REGISTRAR DATE AUG 24 '60		24b. REGISTRAR'S SIGNATURE James S. Frawley	

WILEY-BLANKENHORN

 $VD \pm 0.002$

1011

John A. Lee, Copyrightable, 1974

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8905

CERTIFICATE OF DEATH

08878

Item 2 Film 5-71-9-19-60 et

1. PLACE OF DEATH o. COUNTY Catonsville Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY 140 S. Patterson Pl. Ave. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md. 31 3U01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph Nursing Home		d. STREET ADDRESS 133 N. Collington Ave. Tugwell Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Aniela Polkowski		4. DATE OF DEATH Month Day Year Aug. 24, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1882
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months 23 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sr. M. Laurentia Tugwell Drive		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Covindry Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to August 1960 that (I) (we) last saw the deceased alive on July 2, 1960 , and that death occurred at 7:29 AM , from the causes and on the date stated above.			
22a. SIGNATURE Walter E. James		22b. DATE SIGNED 8/25/60	
22c. PHYSICIAN'S NAME (Type) Walter E. James, M.D.		22d. ADDRESS 5550 Baltimore National Pike, Balt 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 26/60	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Of Mary		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozazewski		25a. REC'D BY REGISTRAR 1930 Eastern Ave	
25b. REGISTRAR'S SIGNATURE August 26, 1960		25c. REGISTRAR'S SIGNATURE Arthur L. Krasinski	

08278

8205

Catonville Baltimore Co.

Catonville

St. Joseph Nursing Home

Angela Polkowski

Female White X

House Wife

Unk.

Unk.

St. E. Laurence's Tugwell Drive

Aug. 24, 1968

Aug. 1, 1968 78

Poland U.S.A.

Enlist Aug. 20/80 Exposed heart of heart Baltimore

Fred W. Orlowski 1980 Bessie Ave

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

Shipped by hearsto: John M. Taylor, Duke of Gloucester St., Annapolis, Md.

1
8906
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08879.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 61 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 101 Chesapeake Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EUGENE Middle D. Last RECKNER				4. DATE OF DEATH Month August Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1899	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 61 Days 14 Hours 02 Min. 00		11. BIRTHPLACE (State or foreign country) Meyersdale, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter-Retired				10b. KIND OF BUSINESS OR INDUSTRY (Gov't Civil Service) Naval Academy,			
13. FATHER'S NAME Hezekiah Reckner				14. MOTHER'S MAIDEN NAME Lillian Mull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. None		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL DUE TO BRONCHOGENIC CARCINOMA, LEFT UPPER LOBE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, MARKED, GENERALIZED -OLD							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (H) (this hospital) attended the deceased from June 8, 1960 to August 8, 1960 , that (H) (we) last saw the deceased alive on August 8, 1960 , and that death occurred at 7:43 P M, from the causes and on the date stated above.							
22a. SIGNATURE FREDERICK S. DONALDSON, M.D.				22b. DATE SIGNED 8/9/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-12-60		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemetery Annapolis, Maryland		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight, Inc.				25a. REC'D BY REGISTRAR AUG 12 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

02258

CERTIFICATE OF DEATH

8908



Blank form with faint horizontal lines and vertical columns for data entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

VP AIS (4)
ISM 9/59

1
8907
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08880

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle — Last REDD		4. DATE OF DEATH Month AUGUST Day 4 Year 19 60	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 17, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN REDD		14. MOTHER'S MAIDEN NAME MELINDA CHICKAWOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 220-09-0002	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIV		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA INDEX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EMPHYSEMA INDEX (c) ARTERIOSCLEROSIS, MARKED, GENERALIZED AORTIC ANEURYSM, ABDOMINAL		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 19, 1960 , to August 4, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 4, 1960 , and that death occurred at 11:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE HOWARD KRAMER		22b. DATE SIGNED 8-4-60	
22c. PHYSICIAN'S NAME (Type) HOWARD KRAMER		22d. ADDRESS VAH BALTO MD * FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-8-60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Collick Funeral Home		25a. REC'D BY REGISTRAR DATE AUG 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

08880

CERTIFICATE OF DEATH

880

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8908

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 15, 16 Film G269 8-22-60 et

Reg. Dist. No.

08881

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks Pt-19</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		53	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beau Creek</u>		d. STREET ADDRESS <u>3007 Dunglew Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Willis Hauck</u> Middle <u>Reisinger</u> Last <u>—</u>		4. DATE OF DEATH <u>Aug 4/60</u> 7 Month Day Year <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 29 1928</u>
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>steam ship</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Willis T Reisinger</u>		14. MOTHER'S MAIDEN NAME <u>Mildred N Hauck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1948-1954</u>		16. SOCIAL SECURITY NO. <u>217-24-2822</u>	
17. INFORMANT <u>Willis T Reisinger</u>		Address <u>3007 Dunglew Road</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently fell from Boat into Beau Creek</u>	
20c. TIME OF INJURY Month, Day, Year <u>7</u> Hour <u>8-3</u> p. m. <u>1960</u>		20d. INJURY OCCURRED <u>While</u> <input checked="" type="checkbox"/> <u>Not while</u> <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> <u>Beau Creek</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beau Creek</u>		20f. (City or town) <u>Sp Pt-19</u> (County) <u>Baltimore</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 6/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	
DATE <u>AUG 9 '60</u>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

89099

CERTIFICATE OF DEATH

10025

Item 11 Film 4273 10-14-60 et

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>4 yrs. 11 days</u>		d. STREET ADDRESS <u>1523 Eutaw Place</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Jane</u> Last <u>Reno</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Andy Sheets</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Gady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records: Spring Grove State Hospital - Catonsville - Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.0</u> DUE TO <u>15 hrs</u> Status Epilepticus & Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Chronic Brain Syndrome - Senile Brain Disease - Convulsive Disorder</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 21, 1960</u> , to <u>August 21, 1960</u> , that (I) (we) last saw the deceased alive on <u>August 21, 1960</u> , and that death occurred at <u>4:25 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Gertrude J. Fleischman</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>Aug. 21, 1960</u>
22c. PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMAN</u>		22d. ADDRESS <u>42 Maple Drive, Cat.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9-30-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>W. Med. School</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR DATE <u>OCT 3 '60</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

10000

CERTIFICATE OF DEATH

10000

1

MADE IN U.S.A.
COLUMBIA P. CO.

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/58

88283

CERTIFICATE OF DEATH

891

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John A. Jones		45		Male		White		March 15, 1968		New York, N.Y.	
Cause of Death		Occupation		Education		Marital Status		Date of Birth		Place of Birth	
Heart Disease		Teacher		High School		Married		March 22, 1923		New York, N.Y.	
Physician's Signature		Hospital		City		State		County		Zip	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Issued By		Title		Institution		City		State	
March 16, 1968		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

CERTIFICATE OF DEATH

Reg. Dist. No. 08883

8802

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) Glen Falls Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gerdetta Middle Effie Last Rimbey				4. DATE OF DEATH Month Aug. Day 1, Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3. 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Smith				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Mr. George C. Rimbey Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Decomposition 443X DUE TO Myocardial Decomposition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Decomposition DUE TO Myocardial Decomposition (c) Myocardial Decomposition DUE TO Myocardial Decomposition							INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-1960 to 8-1-60 , that I lost saw the deceased alive on 8-1-60 , and that death occurred at Reisterstown, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Reisterstown, Md. 8-1-60							
ACTUAL SIGNATURE James C. Saffell M.D.		PHYSICIAN'S NAME (Type) James C. Saffell M.D. Reisterstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Gilead		22d. LOCATION (City, town, or county) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons				ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08883

CERTIFICATE OF DEATH

8005



Baltimore

Baltimore

Place of Birth

Place of Birth

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8799

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08884

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 Hillendale Road		d. STREET ADDRESS 202 Hillendale Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Barbara Middle D. Last Robinson		4. DATE OF DEATH Month August Day 1 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1895
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Walz		14. MOTHER'S MAIDEN NAME Barbara ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Walter W. Robinson		Address 202 Hillendale Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Arteriosclerotic CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH Sudden ? yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1952 to August 1, 1960 , that (I) (we) lost the deceased alive on 7/28 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Herbert J. Levickas		22b. DATE 8/2/60	
22c. PHYSICIAN'S NAME (Type) Herbert J. Levickas, M. D.		22d. ADDRESS 5305 East Drive or 2436 Wash. Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/4/60	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25. REGISTRAR'S SIGNATURE Arthur S. Kline	
25a. REC'D BY REGISTRAR AUG 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

108281

DECLARATION OF DEATH

2539



Baltimore

MD

Baltimore

Indemnity

Indemnity

200 WILKINS AVE

2 ELLIOTT ST

Robinson

Robinson

June 28, 1902

White

male

Baltimore, Maryland U. S. A.

Housewife

Barber

John W. J.

Witness: M. Robinson 200 Wilkins Ave.
Indemnity No.

No.

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complete file

8911

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10031

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.			c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie 0260-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 305 Raleigh Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle M. Last ROBINSON				4. DATE OF DEATH Month August Day 30 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1909		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY Chemical Company		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Thomas Robinson				14. MOTHER'S MAIDEN NAME Queen Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-14-1576		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: BRONCHOPNEUMONIA, RIGHT LUNG 491X XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE XXXX (c) ACUTE GASTRITIS						INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE TOXIC HEPATITIS, RECENT						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from August 28, 1960 to August 30, 1960 , that (X) (we) last saw the deceased alive on August 30, 1960 , and that death occurred at 11:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick S. Donaldson</i>				22b. ADDRESS VAH, BALTO. 18 MD, FORT HOWARD DIVISION		22c. DATE SIGNED 8/30/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-4-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson, 1000 Brantley Ave., Balto. Md.				25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>	

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1961

CERTIFICATE OF DEATH

1188

Decedent's Name: [Illegible]
Date of Birth: [Illegible]
Sex: [Illegible]
Race: [Illegible]
Marital Status: [Illegible]
Place of Birth: [Illegible]
Usual Residence: [Illegible]

Decedent's Address: [Illegible]
City: [Illegible] State: [Illegible] Zip: [Illegible]
Date of Death: [Illegible]
Time of Death: [Illegible]

Cause of Death: [Illegible]
Manner of Death: [Illegible]
Physician's Name: [Illegible]
Physician's Address: [Illegible]

Medical History: [Illegible]
Present Illness: [Illegible]
Treatment: [Illegible]
Date of Admission: [Illegible]

History of Present Illness: [Illegible]
Physical Examination: [Illegible]
Laboratory Studies: [Illegible]
X-ray Studies: [Illegible]

Pathological Findings: [Illegible]
Microscopic Examination: [Illegible]
Gross Examination: [Illegible]
Diagnosis: [Illegible]

Postmortem Examination: [Illegible]
Toxicology: [Illegible]
Other Studies: [Illegible]
Signature of Physician: [Illegible]

Signature of Medical Examiner: [Illegible]
Signature of Coroner: [Illegible]
Signature of Registrar: [Illegible]
Date of Issuance: [Illegible]

Official Seal: [Illegible]
Remarks: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8912

08885

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 E. Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Muriel Alice Robinson		4. DATE OF DEATH Month Day Year August 14, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1914
9. AGE (In years lost birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Caddell		14. MOTHER'S MAIDEN NAME Harriett Burns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. William S. Robinson, Sr., Towson, Maryland	
17. INFORMANT William S. Robinson, Sr., Towson, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Carcinoma Rt. Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 10 1960 to Aug 14 1960 , that (I) (we) last saw the deceased alive on Aug 14 1960 , and that death occurred at 9:20 P. from the causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED 8/16/60	
22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST		22d. ADDRESS 6805 York Rd. Baltimore 12 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 17, 1960	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City, town, or county) (State) Parkville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		ADDRESS John Burns' Sons, Towson, Maryland	
25a. REC'D BY REGISTRAR DATE AUG 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

08885

CERTIFICATE OF DEATH

801

Witness

Witness

Witness

Witness

Witness

Witness

Attest: John J. Jones

Attest: John J. Jones

Attest: John J. Jones

Attest: John J. Jones

Attest: John J. Jones

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Attest: John J. Jones

Attest: John J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8913

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

08886

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILL</u> b. COUNTY <u>Keenes</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keenes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edgeway Manor Nursing Home</u>		d. STREET ADDRESS <u>SIX-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Wayne</u> Middle <u>Satterfield</u> Last <u>Field</u>		4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1894</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	
11. BIRTHPLACE (State or foreign country) <u>Winchester, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Satterfield</u>		14. MOTHER'S MAIDEN NAME <u>Bettie Lake NAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>16707-6805</u>	
17. INFORMANT <u>Masood Funeral Home - Saxton - Pa</u>		Address <u>Saxton - Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senescent Carcinomatous</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>180X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1960</u> to <u>Aug 14, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 14, 1960</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Nelson Mudge</u>		22b. DATE SIGNED <u>Aug 14, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Nelson Mudge</u>		22d. ADDRESS <u>Aug 14, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>8/14/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Devoll</u>		23d. LOCATION (City, town, or county) (State) <u>Six Mile Run, Bedford Co. Pa</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner, Sons</u>		25a. REC'D BY REGISTRAR <u>Aug 15 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinnel</u>		25c. REGISTRAR'S SIGNATURE	

08888

8812



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8914

CERTIFICATE OF DEATH

08887
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 31 Yrs. 2 Mos. 2 Ds. d. NAME OF HOSPITAL (If not in hospital, give street address) Sheppard and Enoch Pratt Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Dover c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 72X-3 d. STREET ADDRESS Cumberland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Martha Last Scheffer		4. DATE OF DEATH Month August Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1875
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months 2 Days 4 Hours 2 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jeremiah Reeves		14. MOTHER'S MAIDEN NAME Jane Rees	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Myocardial fibrosis (c) Generalized Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 Years 15 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cold abscess, old, of iliocecal area, issuing from lesion of cecum.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21, 1929 , to Aug 23, 1960 , that I last saw the deceased alive on Aug 22, 1960 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Harry M. Murdock		M.D. August 23, 1960 The Sheppard and Enoch Pratt Hospital Towson 4, Maryland	
PHYSICIAN'S NAME (Type) Harry M. Murdock, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL/BURIAL AUG. 26, 1960		22b. DATE THEREOF AUG. 26, 1960	
22c. NAME OF CEMETERY OR CREMATORY MAPLE GROVE CEM.		22d. LOCATION (City, town, or county) DOVER, OHIO (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 26 '60		24b. REGISTRAR'S SIGNATURE William S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death: _____ Place of Death: _____	
Decedent's Name: _____ Sex: _____ Age: _____	
Date of Birth: _____ Place of Birth: _____	
Usual Residence: _____ Date of Admission to Hospital: _____	
Date of Discharge: _____ Cause of Death: _____	
Immediate Cause: _____ Underlying Cause: _____	
Contributing Cause: _____ Manner of Death: _____	
Physician's Name: _____ Hospital Name: _____	
Registrar's Name: _____ Date of Registration: _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

8915

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10039

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 6 Hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 30 d. STREET ADDRESS 2620 Kent Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last SCHULTZ		4. DATE OF DEATH Month August Day 31 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1907
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Seton Institute	
11. BIRTHPLACE (State or foreign country) Lovejoy, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Don Schultz		14. MOTHER'S MAIDEN NAME Ella Randolph	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FT. HOWARD DIVISION		Address Clin. Rec. VAH, Baltimore 18, Md. FT. HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 8/31/60 1:00 PM to 8/31/60 7:00 PM , that (X) (we) last saw the deceased alive on 8/31/60 19 60 , and that death occurred at 7 PM , from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson		22b. DATE SIGNED 8 9/1/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/6/1960	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Isaiah Brown & Son, 108 W. Montgomery St. Balto. Md.		25a. REC'D BY REGISTRAR SEP 8 1960	
ADDRESS Isaiah Brown & Son, 108 W. Montgomery St. Balto. Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

10123

CERTIFICATE OF DEATH

8312

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
COUNTY OF ALBANY

DATE OF DEATH: 10/15/1960
TIME OF DEATH: 10:30 AM
PLACE OF DEATH: HOME

DECEASED: JOHN J. SMITH
AGE: 68
SEX: MALE
RACE: WHITE
MARRIAGE: MARRIED

CAUSE OF DEATH: HEART DISEASE
IMMEDIATE CAUSE: MYOCARDIAL INFARCTION
UNDERLYING CAUSE: ARTERIO-SCLEROSIS
MORBIDITY: 10/15/1960

REPORTED BY: DR. J. J. SMITH
SIGNATURE: J. J. SMITH
ADDRESS: 123 MAIN ST., ALBANY, N.Y.

FILE NO. 10123

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8916

CERTIFICATE OF DEATH

08888
Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 9 MOS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. STREET ADDRESS Rt. I-326		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BEULAH First GENEVIEVE Middle SCHULZE Last				4. DATE OF DEATH Month August Day 19 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7.5.1896.	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRED COMLEY				14. MOTHER'S MAIDEN NAME SARAH E. PORTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-12-9762		INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 15 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Toxic Goiter. 2. Minimal Pulmonary Tuberculosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11.30. , 19 57 , to 8.19. , 19 60 , that I last saw the deceased alive on 8.19. , 19 60 , and that death occurred at 8 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED							
ACTUAL SIGNATURE William Newcomer				M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug. 23 1960		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & KIRKLEY				24a. REC'D BY REGISTRAR DATE AUG 23 '60		24b. REGISTRAR'S SIGNATURE Allen S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8316

CERTIFICATE OF DEATH

8328

John A. ...

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GENEVIEVE SCHOLZ

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USA

PORTER

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8917

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>83</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>6234 Falls Road</u>				d. STREET ADDRESS <u>16234 Falls Road</u>			
3. NAME OF DECEASED (Type or print) <u>HENRIETTA A. SCOTT</u>				4. DATE OF DEATH <u>Aug 3 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 16 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>JOHN T. GREEN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH DIXON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>ESTER SCOTT-FALLS ROAD</u>				Address <u>6234</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic valvular disease of heart</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>60</u> , to <u>8-3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-2</u> , 19 <u>60</u> , and that death occurred at <u>9 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John E. S. Camper</u>				ADDRESS (Street, city or town, state) <u>639b Carey St. Baltimore, Md.</u>			
DATE SIGNED <u>8-5-60</u>							
PHYSICIAN'S NAME (Type) <u>JOHN E. T. CAMPER</u>				ADDRESS <u>639b Carey St. Balto. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RUXTON CEM.</u>		22d. LOCATION (City, town, or county) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Smith</u>				ADDRESS <u>3035 W. North Ave.</u>		24a. REGISTERED <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hulse</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8918

Item 1 Film 6269 8-22-60 et

CERTIFICATE OF DEATH

08890

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home - 17 Bishops Lane				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
				d. STREET ADDRESS 1 17 Bishops Lane			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Seicke				4. DATE OF DEATH Month 8 Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-1880	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 8 Days 14 Hours 19 Min. 60		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Ret.			
13. FATHER'S NAME Adolph Seicke				14. MOTHER'S MAIDEN NAME ----- Buppert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Eleanor Baker				Address Ellicott City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Arricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Renal Disease (c) 2 weeks 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3.31 19 55 to 8.14 19 60 , that (I) (we) last saw the deceased alive on 8.14 19 60 and that death occurred at 8:30 P. M, from the causes and on the date stated above.							
22a. SIGNATURE George E. Urban				22b. DATE SIGNED 8.15.60			
22c. PHYSICIAN'S NAME (Type) George E. URBAN				22d. ADDRESS 805 Frederick Ave 28 Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-17-1960		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City, town, or county) (State) Howard County Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Macnatt & Son				25a. REC'D BY REGISTRAR DATE AUG 18 '60			
ADDRESS 301 Frederick Ave-28-				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

222

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8803

CERTIFICATE OF DEATH

Reg. Dist. No.

08891

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Butler Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Shaeffer		4. DATE OF DEATH Month August 17, Day 1960 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 5 Days 17 Hours 3 Min.	11. IF UNDER 24 HRS. Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paterick McCartin		14. MOTHER'S MAIDEN NAME Mary Spencer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. J.E. Shaeffer		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 443 X IMMEDIATE CAUSE (a) Uremic Coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hyper tension arteriosclerosis myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 3 days 5 yr 3 yr		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 yr 3 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-59 to 8-17-60 , that I last saw the deceased alive on 8-16-60 , and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Md 21158 DATE SIGNED 8-18-60			
ACTUAL SIGNATURE James G. Saffell M.D.		DATE SIGNED 8-18-60	
PHYSICIAN'S NAME (Type) James G. Saffell		ADDRESS Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20, 1960	
22c. NAME OF CEMETERY OR CREMATORY All Saints Cemtery		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE AUG 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

8919

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard	
c. LENGTH OF STAY IN 1b 23 Yrs.		d. STREET ADDRESS 15 Todd Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 5 Todd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Claude Middle L. Last Sherow		4. DATE OF DEATH Month August Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1901
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 3 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Potentialometer Oper. Beth. Steel		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Sherow		14. MOTHER'S MAIDEN NAME Sarah Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes-Army 1920-35		16. SOCIAL SECURITY NO. 213-07-3629	
17. INFORMANT Mrs. Lucille Sherow		Address 5 Todd Ave. 19, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma Stomach DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1952 , to Aug 15 , 1960, that I last saw the deceased alive on Aug 15 , 1960, and that death occurred at 12:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Means		DATE SIGNED 8-17-60	
PHYSICIAN'S NAME (Type) James T. Means		ADDRESS (Street, city or town, state) 5200 51st. Balto., 19 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 18, 60	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Washington Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR AUG 18 '60		24b. REGISTRAR'S SIGNATURE Arthur L. F...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8920
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08893

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 9yr2mth2dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2208 Henneman Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Imogene Middle Simms Last Simms				4. DATE OF DEATH Month August Day 4 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 18, 1919	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 4 Days 11 Hours 58 Min.		IF UNDER 24 HRS. Hours 11 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Bennett				14. MOTHER'S MAIDEN NAME Ella Youngblood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Carcinoma right breast, ulcerative DUE TO (c) 1 year				INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 4, 1960 to Aug. 4, 1960 that (I) (we) last saw the deceased alive on Aug. 4, 1960 , and that death occurred at 11:58 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 8-4-60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug. 19, 60 St. Peter		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Balto. Md		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Mannatt & Son Co (28)				ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Frame			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8921

CERTIFICATE OF DEATH

Reg. Dis. No. 18894

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Julie		d. STREET ADDRESS Valley Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Cecilia, S.H. (Anastasia McGrath)		4. DATE OF DEATH Month Day Year Aug. 15, 1960 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1889
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min. 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher- Ret		10b. KIND OF BUSINESS OR INDUSTRY Religious	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. McGrath		14. MOTHER'S MAIDEN NAME Bridget ---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. --	
INFORMANT Sister Mary Patrick- Villa Julie		Address Villa Julie	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of the breast. DUE TO lying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 6 months 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 59 , to Aug 15 , 19 60 , that I last saw the deceased alive on Aug 14 , 19 60 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold H Burns		ADDRESS (Street, city or town, state) DATE SIGNED 115 East Eager Street Baltimore 2, Maryland 7-7-60	
PHYSICIAN'S NAME (Type) Harold H. Burns, M.D.		Baltimore 2, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-18-60	22c. NAME OF CEMETERY OR CREMATORY Trinity Convent Cem.	22d. LOCATION (City, town, or county) (State) Ilchester, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home, Catonsville, Md.		24a. REC'D BY REGISTRAR DATE AUG 23 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1951

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8922 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08895
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARL</u> First <u>LYNN</u> Middle <u>SIVITS</u> Last		4. DATE OF DEATH <u>8/27/60</u> Month <u>8</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1934</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>	9. AGE (In years last birthday) <u>26</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Johnstown, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry A. Sivits</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Elva Layton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harry A. Sivits - New Paris, Penna.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head, short range</u> DUE TO <u>976X</u> Conditions, if any, which gave rise to immediate cause (b) <u>976X</u> (c), stating the underlying cause lost. DUE TO <u>976X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>976X</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head</u>	
20c. TIME OF INJURY Month, Day, Year <u>10</u> Hour <u>8</u> p.m. <u>8/27/1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u>		20f. (City or town) <u>Gunpowder Falls, Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Bratley King, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. Bratley King, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/28/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/31/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fishertown Cemetery</u>		22d. LOCATION (City, town, or county) <u>Fishertown, Penna.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto., Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 30 '60</u> DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>L. T. Tiekner</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
Baltimore, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8923

CERTIFICATE OF DEATH

08896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY West Virginia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA 10 Box 300				c. LENGTH OF STAY IN 1b Morgantown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				d. STREET ADDRESS 164 Hodes Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last SMITH				4. DATE OF DEATH Month 8-6-60 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 14, 1882	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.		IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Christopher Smith				14. MOTHER'S MAIDEN NAME Amelia Shaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Fred L. Jenkins		Address Morgantown, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carinoma of femur & diffuse metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) metastasis DUE TO (c) metastasis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1966.7							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 2, 1960, to Aug 5, 1960 , that I last saw the deceased alive on Aug 6, 1960 , and that death occurred at 6:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 914 D Street, Sparrows Point, Md. DATE SIGNED 8-8-60							
ACTUAL SIGNATURE John V. Conway				M.D. 914 D Street, Sparrows Point, Md.			
PHYSICIAN'S NAME (Type) John V. Conway				914 D Street, Sparrows Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-7-60		22c. NAME OF CEMETERY OR CREMATORY Beverly Hill Memorial		22d. LOCATION (City, town, or county) (State) Morgantown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc. L217 St. Paul St.				24a. REC'D BY REGISTRAR DATE AUG 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

08830

CERTIFICATE OF DEATH

8823

THE REGISTRAR, West Virginia

MORTONSTOWN

154 Hoken Ave.

8-8-50

Sept 14, 1985

West Virginia Railroad

Amelia Shaw

West I. Jenkins, Morgantown, W. Va.

John V. Conway

John V. Conway

Morgantown, W. Va.

West Hill Memorial

West Hill Memorial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8924
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08897

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 153 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle H Last SMITH		4. DATE OF DEATH Month AUGUST Day 10 Year 19 60	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 18, 1890
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		12. KIND OF BUSINESS OR INDUSTRY GENERAL HAULING	
13. FATHER'S NAME JOSEPH SMITH		14. MOTHER'S MAIDEN NAME JANE KEENE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT CLIN. REC. VET ADM HOSPITAL BALTO MD FT HOWARD		Address DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO ARTERIOSCLEROTIC HEART DISEASE (b) ADENOCARCINOMA, PROSTATE WITH METASTASES TO BONE (c) ENCEPHALOMALACIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. XXRXXX PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, OLD.		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 10 3:00 PM 1960 to August 10 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 11 1960 , and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE FREDERICK S. DONALDSON M.D.		22b. DATE 8/11/60	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/15/60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips		25a. REC'D BY REGISTRAR DATE AUG 15 '60	
ADDRESS 1808 N Monroe St Balto Md		25b. REGISTRAR'S SIGNATURE Cirking S. Hume	

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8925

CERTIFICATE OF DEATH

08898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. *If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Calverton</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>				2201-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Parade Nursing Home Md.</u>				d. STREET ADDRESS <u>22 46 Wickens Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE MAY SMITH</u>				4. DATE OF DEATH Month Day Year <u>8 16 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 6 1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St Agnes Hospital - storeroom work Balt. Md.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>u SA</u>			
11. BIRTHPLACE (State or foreign country) <u>u SA</u>				12. CITIZEN OF WHAT COUNTRY? <u>u SA</u>			
13. FATHER'S NAME <u>John G. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-14-1262</u>			
17. INFORMANT <u>Mrs. Ella Rauch</u>				Address <u>22 46 Wickens Ave #23</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Baltimore Md</u>			
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John M. Gerwig</u> M.D.				ADDRESS (Street, city or town, state) <u>400 Grealan Rd. Balt. Md 8/16/60</u>			
PHYSICIAN'S NAME (Type) <u>JOHN M. GERWIG JR</u>				DATE SIGNED <u>8/16/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>8-19-60</u>		<u>London Park</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robt. C. Walters</u> ADDRESS <u>Pratt & Stricker</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8926 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08899

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPARKS		c. LENGTH OF STAY in 1b LIFE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Butler		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Road on or Cold Bottom Road				d. STREET ADDRESS FALLS RD.			
3. NAME OF DECEASED (Type or print) First ROBERT Middle E. Last SMITH				4. DATE OF DEATH Month August Day 23 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 19 1933		9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months 26 Days 26	IF UNDER 24 HRS. Hours 26 Min. 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHINA WORK		10b. KIND OF BUSINESS OR INDUSTRY STORE		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HARRY T. SMITH				14. MOTHER'S MAIDEN NAME MILDRED LEE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES U.S. AR		16. SOCIAL SECURITY NO. unkn		17. INFORMANT Bernice Smith - 412 E. Oliver St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head					
20c. TIME OF INJURY Month, Day, Year Aug. 5-6 8/22 19 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Auto		20f. (City or town) B	(County) Baltimore	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/24/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/60		22c. NAME OF CEMETERY OR CREMATORY Lough		22d. LOCATION (City, town, or country) (State) Cockeysville Park, Co. Md.	
23. FUNERAL DIRECTOR Wm. L. Britton Jr. - 1701 Mt. Calver St. - Baltimore, Md.				24a. REC'D BY REGISTRAR AUG 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

8058



Number wound of head

Spot hole in head

W. H. H. H.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8927 CERTIFICATE OF DEATH

Reg. Dist. No. 08900

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> 1507 W. Joppa rd. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson 4</i>		c. LENGTH OF STAY IN lb <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William James Sneeringer Jr.</i>		4. DATE OF DEATH * <i>8-21-60</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-4-1880</i>
9. AGE (In years lost birthday) <i>79</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto Trust Co. Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. J. Sneeringer, Sr.</i>		14. MOTHER'S MAIDEN NAME <i>? Unlack</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>217-14-0966</i>	
17. INFORMANT <i>Mrs. Hettie C. Sneeringer (wife)</i>		Address <i>same as #1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lymphosarcoma</i> <i>200.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebrovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 20, 1960</i> to <i>Aug 21, 1960</i> that I last saw the deceased alive on <i>Aug 20, 1960</i> , and that death occurred at <i>1:40 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1201 University Pkwy, Baltimore, Md.</i>	
ACTUAL SIGNATURE <i>William J. Fritz</i> M.D.		DATE SIGNED <i>8/22/60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-23-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Gunpowder Friends Meeting Sparks Md.</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks Funeral Ser. 622 York Rd. Towson Md.</i>		24a. REC'D BY REGISTRAR <i>AUG 24 60</i>	
24b. REGISTRAR'S SIGNATURE <i>William S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1907

REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 10, 1907

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
1907.

NEW YORK: J. B. LIPPINCOTT & CO., PRINTERS.
1907.

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NEW YORK: J. B. LIPPINCOTT & CO., PRINTERS.
1907.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.
1907.

1 **FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

<div> <div> <div>8928</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div>08901</div> </div>																	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wendover c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7836 Harford Rd.						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Wendover 7836 Harford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Leonid			4. DATE OF DEATH Month August Day 26 Year 19 60			5. SEX Male			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner			10b. KIND OF BUSINESS OR INDUSTRY Restaurant			8. DATE OF BIRTH 9-23-1922			9. AGE (In years last birthday) 37 yrs. If UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS.: Hours _____ Min. _____			11. BIRTHPLACE (State or foreign country) Ukraine White Russia					
13. FATHER'S NAME Aphanasi Solonsky						14. MOTHER'S MAIDEN NAME Anna											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO. Amalie M. Solonsky						17. INFORMANT same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of abdomen; contact type. DUE TO (b) 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Shot self before eye witnesses													
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. 8/26/60 19 p.m.				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		2Df. (City or town) Baltimore-Baltimore		(County) Baltimore		(State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 27, 1960			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)													
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 8-29-60		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.				22d. LOCATION (City, town, or country) Baltimore, Md.							
23. FUNERAL DIRECTOR Leonard R. Ruck 5305 Harford Rd.						24a. REC'D BY REGISTRAR AUG 30 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline									

108001

8058 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Residence

City

State

Age

Sex

Occupation

Date

Time

Place

Cause

Manner

Signature

Medical Examiner

Signature of Physician

Signature of Witness

Date

Time

W. H. H.

Signature of Physician

Signature of Medical Examiner

Signature of Witness

12
FOR STATE HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
8929 08902													
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. LENGTH OF STAY IN 1b X Parkville									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8207 Harford Road				d. STREET ADDRESS 8207 Harford Road									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) HENRY				4. DATE OF DEATH August 31, 1960									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1892		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Spielman				14. MOTHER'S MAIDEN NAME Wilhelmina Jasper									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Dora Brendel 8305 Harford Rd. 11					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of left chest DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) 9776X												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest									
20c. TIME OF INJURY Month, Day, Year Aug. 31, 1960				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		20f. (City or town) Baltimore, Md.		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Russell S. Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 8/31/60					
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
				Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3, 1960		22c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran				22d. LOCATION (City, town, or country) (State) Harford Rd. Balto. Co. Md.					
23. FUNERAL DIRECTOR Lanahan Funeral Home				ADDRESS 7401 Belair Rd.				24a. REC'D BY REGISTRAR SEP 2 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8930

CERTIFICATE OF DEATH

08903

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 28 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 318 N. Carrollton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last STANSBURY			4. DATE OF DEATH Month August Day 24 Year 1960		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 4, 1889		9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR: Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Retired		10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME James Stansbury			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME Anna MN: Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		
16. SOCIAL SECURITY NO. 215-07-3521			17. INFORMANT Clinical Records, VAH, Baltimore 18, Md. DIVISION		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL DUE TO BRONCHOGENIC CARCINOMA, LEFT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA, LEFT ADRENAL AND LEFT CEREBELLAR HEMISPHERE (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Arteriosclerosis, generalized. 2. Chronic hemorrhagic cystitis. 3. Benign prostatic hypertrophy.					INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour — o. m. — p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —		20g. (County) —		20h. (State) —	
21. I certify that (this hospital) attended the deceased from July 27, 1960 to August 24, 1960 , that (we) last saw the deceased alive on August 24, 1960 , and that death occurred at 11:00 PM , from the causes and on the date stated above.					
22a. SIGNATURE Frederick S. Donaldson			22b. DATE 8/25/60		
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.			22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 30, 1960		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem	
23d. LOCATION (City, town, or county) Baltimore		23e. (State) Maryland		23f. (Country) —	
24. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams			25a. REC'D BY REGISTRAR DATE AUG 31 '60		
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			25c. (City, town, or county) —		
25d. (State) —			25e. (Country) —		

02003

CERTIFICATE OF DEATH

8830

Residence

Residence

Age

Age

Place of Birth

Place of Birth

Occupation

Occupation

Marital Status

Marital Status

Cause of Death

Cause of Death

Cause of Death

Time of Death

Time of Death

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8931

CERTIFICATE OF DEATH

Reg. Dist. No.

08904

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore-14</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>2526 Wycliffe Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>W</u> Middle <u>STEFFEY</u> Last		4. DATE OF DEATH <u>Aug.</u> Month <u>4</u> Day <u>1960</u> Year					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1871</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry W. Steffey</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>G.H. Steffey (son)</u> Address <u>2526 Wycliffe Rd. 14</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Cardio-vascular dis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>none</u> DUE TO (c) <u>none</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year <u>none</u> 19 <u>60</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 21, 1960</u> to <u>Aug. 4, 1960</u> , that I last saw the deceased alive on <u>July 21, 1960</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Bacon</u> M.D.		ADDRESS (Street, city or town, state) <u>2810 Taylor Ave. Baltimore-14-Md.</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>A. M. B A C O N</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 6, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc.</u> ADDRESS <u>1050 York Rd.</u>				24a. REC'D BY REGISTRAR <u>AUG 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8932

CERTIFICATE OF DEATH

Reg. Dist. No.

10048

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HOME		d. STREET ADDRESS 8 Randall Ave.	
3. NAME OF DECEASED (Type or print) ANNIE ELIZABETH STEIGERWALD First Middle Last		4. DATE OF DEATH AUGUST 29 1960 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 27, 1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Wesley Palmer	
14. MOTHER'S MAIDEN NAME Sarah Neff		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Esther S. Ray Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LIVER 156-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) osteoarthritis			INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 29 19 60 , and that death occurred at 4:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis 2. Dalman		ADDRESS (Street, city or town, state) Pikesville Md. DATE SIGNED 8/31/60	
PHYSICIAN'S NAME (Type) Louis 2. DALMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Sept. 1, 1960	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville 8, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR SEP 8 '60	24b. REGISTRAR'S SIGNATURE William S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8933

CERTIFICATE OF DEATH

08905

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rose Dale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rose Dale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6518 Golden Ring Rd</u>				d. STREET ADDRESS <u>16518 Golden Ring Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C.</u> Last <u>STINSON</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1891</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>60</u>		IF UNDER 24 HRS. Months <u>10</u> Days <u>19</u> Hours <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George STINSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Failure</u> <u>422.1</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Pulmonary Emphysema</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4.29</u> , 19 <u>59</u> , to <u>8.10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8.10</u> , 19 <u>60</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Orth, M.D.</u>				ADDRESS (Street, city or town, state) <u>8019 Philadelphia Road</u> DATE SIGNED <u>8.11.60</u>			
PHYSICIAN'S NAME (Type) <u>John G. Orth, M. D.</u>				Baltimore 6, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Orth</u>				ADDRESS <u>269 Lake Rd</u>		24a. REC'D BY REGISTRAR <u>Aug 15 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]		DATE OF BIRTH [Handwritten: 10/15/1880]		PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
OCCUPATION [Handwritten: Clerk]		MARITAL STATUS [Handwritten: Married]		COLOR [Handwritten: White]		RELIGION [Handwritten: Catholic]		PLACE OF DEATH [Handwritten: Baltimore, Md.]	
CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]		TIME OF DEATH [Handwritten: 10:30 AM]		DATE OF DEATH [Handwritten: 11/1/1925]		PLACE OF DEATH [Handwritten: Home]	
SIGNATURE OF PHYSICIAN [Handwritten: J. H. Smith]		SIGNATURE OF MINISTER [Handwritten: W. J. Brown]		SIGNATURE OF CORONER [Handwritten: C. L. Green]		SIGNATURE OF JURY [Handwritten: J. H. Smith, W. J. Brown, C. L. Green, J. H. Smith, W. J. Brown, C. L. Green]		SIGNATURE OF DECEASED [Handwritten: John Doe]	
CERTIFICATE OF DEATH [Handwritten: I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.]		CERTIFICATE OF DEATH [Handwritten: I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.]		CERTIFICATE OF DEATH [Handwritten: I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.]		CERTIFICATE OF DEATH [Handwritten: I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.]		CERTIFICATE OF DEATH [Handwritten: I hereby certify that the above is a true and correct statement of the facts as stated on the certificate of death.]	

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

8934

CERTIFICATE OF DEATH

08906

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6803 Wellwood Court		d. STREET ADDRESS 4213 Granada Ave.	
3. NAME OF DECEASED (Type or print) First PHILIP Middle H. Last STRAUSS		4. DATE OF DEATH Month 8/13/60 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	11. IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Dairy Products	
13. FATHER'S NAME Nathan Strauss		14. MOTHER'S MAIDEN NAME Rosa Strauss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Betty Strauss-		Address Sane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis generalized DUE TO (c) Hypertension			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 Month Day Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 15, 1956</u> to <u>Aug 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 13, 1960</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Daniel J. Schwartz</i>		22b. PHYSICIAN'S NAME (Type) DANIEL J. SCHWARTZ	
22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 2320 Euteria Place	
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/15/60	
23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC. 6010 Reisterstown Rd.		25a. REC'D BY REGISTRAR DATE AUG 17 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		25c. DATE	

03206

CERTIFICATE OF DEATH

8022

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DATE OF DEATH

DOE TOWN

Bellevue

Bellevue

2503 Wellwood Court

2503 Wellwood Court

DATE

DECEASED

DATE

Sept 1993

DATE

NAME

USA

Bellevue, WA

Bellevue, WA

Inspector

Page 8000000

Page 8000000

Page 8000000

Bellevue, WA

Bellevue, WA

8/1/00

8/1/00

NOTARY PUBLIC

8935

CERTIFICATE OF DEATH

08907

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Henry A. Streib</i>		2. DATE OF DEATH <i>Aug. 20, 1960</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Balto. Co.</i> <i>X</i> <i>5 St. Michaels Way</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto.</i> C. CITY OR TOWN <i>X Baltimore</i> (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <i>5 St. Michaels Way</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i>	8. DATE OF BIRTH <i>Feb. 12-1881</i>
9. AGE (In years last birthday) <i>79</i>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>P.R.R. Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Streib</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Nauman</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Annetta Bristow</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.0 Anteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Chronic Pulmonary Emphysema</i>		(B) <i>5 yrs</i> (C) <i>Anteriosclerosis</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Chronic Pulmonary Emphysema 3 yrs.</i>	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
22. I certify that (I) (this hospital) attended the deceased from <i>April 10-1954</i> to <i>Aug 20 1960</i> , that (I) (we) last saw the deceased alive on <i>Aug 18 1960</i> , and that in (my) (our) opinion death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. SIGNATURE <i>Leonard J. Ruck</i> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS <i>4808 Harford Rd.</i>	23c. DATE SIGNED <i>8/22/60</i>
24a. BURIAL, CREMATION, REMOVAL <i>Burial</i>	24b. DATE <i>8/23/60</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Baltimore</i>	24d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
25a. DATE REC'D BY HEALTH DEPT. <i>AUG 25 '60</i>		25b. NAME OF REGISTRAR <i>John L. Frank</i>	25c. FUNERAL DIRECTOR <i>Leonard J. Ruck</i>
		ADDRESS <i>5305 Harford Rd.</i>	

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04813

CERTIFICATE OF DEATH

STATE OF NEW YORK
COUNTY OF []
CITY OF []
DECEASED []
DATE OF DEATH []
PLACE OF DEATH []
CAUSE OF DEATH []
MANNER OF DEATH []
AGE []
SEX []
RACE []
BIRTH []
MARRIAGE []
EDUCATION []
OCCUPATION []
RELIGION []
SIGNED []
WITNESSED []
NOTARIAL PUBLIC []
Jurat []
Subscribed and sworn to before me this [] day of [] 19[]
Notary Public for the State of New York

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08908**

8936

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Manassas			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas		d. STREET ADDRESS 361 Manassas Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernest Middle Frederick Last Streif				4. DATE OF DEATH Month August Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 20, 1949	
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Streif				14. MOTHER'S MAIDEN NAME June Daniels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Records at Rosewood Owings Mills, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure - due to strangulation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Caused by foreign body in trachea - small apple DUE TO Congenital cerebral Epilepsy - Grand Mal </p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Minutes</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Deceased choked on apple.							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased choked on apple.					
20c. TIME OF INJURY Month, Day, Year 2:15 a.m. Aug. 3 1960		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rosewood School Owings Mills		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Clarence E. McWilliams M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Clarence E. McWilliams M.D. Acting				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR DATE AUG 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8937

CERTIFICATE OF DEATH

Reg. Dist. No.

08999

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glendale, Baltimore</u>		c. LENGTH OF STAY IN IB <u>1 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6742 Glenkirk Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Elizabeth</u> Last <u>Summers</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>13</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Remailer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u> Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Ricks</u>		14. MOTHER'S MAIDEN NAME <u>Mary --</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. Harry R. Summers - 6742 Glenkirk Rd.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive arteriosclerotic vascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>over 10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>August 1960</u> , that I last saw the deceased alive on <u>20 July</u> , 19 <u>60</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u>		ADDRESS (Street, city or town, state) <u>Cochesville 13 August 1960</u>	
PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>		DATE SIGNED <u>1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickerson & Sons - Baltimore</u>		24a. REC'D BY REGISTRAR <u>17th</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton L. ...</u>		DATE <u>AUG 15 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
TSM 9/59

8938

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08910

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4414 Hillside Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland d. STREET ADDRESS 4414 Hillside Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bernard Middle J. Last Sweeting, Sr.		4. DATE OF DEATH Month August Day 17 , Year 1969	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1896
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Balto. Nat'l Bank Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas B. Sweeting		14. MOTHER'S MAIDEN NAME Mary Davidson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 718-10-5872	
17. INFORMANT Emma C. Sweeting		Address 4414 Hillside Ave. #29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. Anteriosclerotic C.V. Disease DUE TO (b) 10 years (c) 1 day		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1955 to Aug 17, 1960 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from the causes and on the date stated above.			
22a. SIGNATURE John F. Coolahan M.D.		22b. DATE SIGNED 8/17/60	
22c. PHYSICIAN'S NAME (Type) John Coolahan, M. D.		22d. ADDRESS 4201 Wilkens Ave - 29	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/20/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25. REC'D BY REGISTRAR AUG 18 '60	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE Charles L. House	

00010

CENTRAL AIR CRAFT

10010

14

Belmont

Belmont

4141 1/2 Avenue

4141 1/2 Avenue

1. Sweeting

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Dec. 1945

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

8939

MONTHS STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08911

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1705 Belt St. 3V01-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last THOMPSON		4. DATE OF DEATH Month 8 Day 7 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 18, 1876
9. AGE (In years lost birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O RR	
11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Family		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease, Cardiac Failure DUE TO Hypertension, Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular Disease DUE TO Atherosclerosis (c) Chronic Pyelonephritis, Rt Central Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 7 days electro gas rw yu	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pyelonephritis, Rt Central Thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1960 to Aug 7, 1960 , that (I) (we) last saw the deceased alive on 7/29/60 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Walter Kohn		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WALTER Kohn		22d. ADDRESS 162 E. Fort Ave. BALTO, 30 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/11/60	
23c. NAME OF CEMETERY OR CREMATORY Westview Cem.		23d. LOCATION (City, town, or county) (State) Atlanta, Georgia	
24. FUNERAL DIRECTOR'S SIGNATURE McGully Funeral Homes		25a. REC'D BY REGISTRAR DATE AUG 10 '60	
ADDRESS 130 E. Fort Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

11030

CERTIFICATE OF DEATH

8828

STATE OF OHIO

8940

CERTIFICATE OF DEATH

08912
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. LENGTH OF STAY IN 1b <i>X</i> <i>Overlea</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6800 Linden Ave. Zone 6,</i>		d. STREET ADDRESS <i>6800 Linden Ave. Zone 6,</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles Emerson Tinker Jr.</i>		4. DATE OF DEATH Month Day Year <i>August 7, 19 60</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 18, 1906</i>
9. AGE (In years last birthday) yrs. <i>53</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Gas & Elec. Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Emerson Tinker Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Rose L. Moran</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-09-9203</i>	
17. INFORMANT <i>Mrs. Eliz. Tinker</i>		Address <i>6800 Linden Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardio-Vascular Disease</i> DUE TO (c) <i>?</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 24, 19 60</i> to <i>August 7, 19 60</i> , that I last saw the deceased alive on <i>August 7, 19 60</i> , and that death occurred at <i>7:58 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>5550 Baltimore National Pike 8/7/60</i>			
ACTUAL SIGNATURE <i>Walter E. James</i> M.D.		PHYSICIAN'S NAME (Type) <i>Walter E. James, M.D. Baltimore 28, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>8/10/60</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Garden of Earth</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruak</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 9 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1932

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8941
CERTIFICATE OF DEATH
08913

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forleigh Nursing Home		d. STREET ADDRESS Temple Garden Apts Madison Avenue	
3. NAME OF DECEASED (Type or print) First SOPHIA Middle TOBIAS Last		4. DATE OF DEATH Month August Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1910
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Public School Sy. Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Moses Tobias		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Abraham Tobias- Temple Garden Apts.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157A IMMEDIATE CAUSE (a) Carcinoma of Pancreas & Metastases to the liver and Regional Lymph Glands and Abdominal Aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Dehydration and Secondary Anemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1959 to Aug 27, 1960 that (I) (we) last saw the deceased alive on Aug 27, 1960 and that death occurred at 4:45 PM from the causes and on the date stated above.			
22a. SIGNATURE H. William Primakoff		22b. DATE SIGNED Aug 28, 1960	
22c. PHYSICIAN'S NAME (Type) H. WILLIAM PRIMAKOFF		22d. ADDRESS EMERSONIAN APTS. BALTO. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 29/60	
23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Road		24a. REC'D BY REGISTRAR SEP 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1901

CERTIFICATE OF DEATH

1901



State of New York
County of ...
City of ...
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the ... day of ... 1901, at the City of ... State of New York, I attended the deceased, ... who died at the residence of ...
The deceased was ... years of age, ...
The cause of death was ...
The death occurred at the residence of ...
The body was buried in the ...
Witness my hand and the seal of my office, this ... day of ... 1901.
Dr. ...
My Comm. Expires ...



Attest:
Notary Public for the State of New York
My Comm. Expires ...
Subscribed and sworn to before me this ... day of ... 1901.
Notary Public for the State of New York
My Comm. Expires ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8942

08914

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 18yr8mth23dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Townsend Last Townsend		4. DATE OF DEATH Month August Day 25 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 4, 1901
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 25 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Michell		14. MOTHER'S MAIDEN NAME Myrtle McKinnon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.1 (c) Gangrenous decubitus ulcers			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrenous decubitus ulcers			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1955 to Aug. 25, 1960 that (I) (we) lost the deceased alive on Aug. 25, 1960 , and that death occurred at 3:38 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED Aug. 25, 1960	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-26-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. Balto. 14		25a. REC'D BY REGISTRAR AUG 29 '60	
25b. REGISTRAR'S SIGNATURE C. L. S. Hume			

08214

CERTIFICATE OF DEATH

8912

41

1. Name of deceased

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08915

8943

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b lyr1ldays	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 3805 Parkview Avenue	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Catherine Last Trexler		4. DATE OF DEATH Month August Day 12 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882 July 30, 1881
9. AGE (In years last birthday) 79 78 yrs.		10. IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edmund Jeffries		14. MOTHER'S MAIDEN NAME Kate Malone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO (b) Generalized arteriosclerosis DUE TO (c) Intertrochanteric fracture of left femur			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 936.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 7-12-60 pt. was pushed down by another patient, striking left hip and sustaining intertrochanteric fracture of left femur	
20c. TIME OF INJURY Month, Day, Year 6:35 a.m. 7-12 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF 8-12-60	
22c. NAME OF CEMETERY OR CREMATORY Mertztown Cemetery		22d. LOCATION (City, town, or county) (State) Longswamp, Burke Co., Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR AUG 15 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hand	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use extra copies of the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8800										DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										08916																								
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																																		
a. COUNTY					Baltimore					MARYLAND					a. STATE					Md.					b. COUNTY					Baltimore														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					Arbutus					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					Arbutus					51																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					4201 Fordham Rd.					d. STREET ADDRESS					4201 Fordham Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																								
3. NAME OF DECEASED (Type or print)					First					Middle					Last					4. DATE OF DEATH					Month					Day					Year									
					Ella M. Turner															8/21/60					19																			
5. SEX					6. COLOR OR RACE					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH					9. AGE (In years lost birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS.														
Female					White					WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					July 25, 1871					89 yrs.					Months					Days					Hours					Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					Housewife					10b. KIND OF BUSINESS OR INDUSTRY					Home					11. BIRTHPLACE (State or foreign country)					Iowa					12. CITIZEN OF WHAT COUNTRY?														
13. FATHER'S NAME					Robert B. Frye					14. MOTHER'S MAIDEN NAME					Katherine Teaple																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					none					16. SOCIAL SECURITY NO.					none					17. INFORMANT					Thelma C. Wells, #201 Fordham Rd.					Address														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).]					PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					156.1					DUE TO					Carcinoma Liver					INTERVAL BETWEEN ONSET AND DEATH					8 yrs.														
					Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.					(b)					DUE TO					(c)																								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					Semility																				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																							
20c. TIME OF INJURY					Month, Day, Year					20d. INJURY OCCURRED					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town)					(County)					(State)														
Hour					a. m.					19					While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																													
p. m.																																												
21. I certify that (I) (this hospital) attended the deceased from Aug 1 1960 to Aug 21 1960, that (I) (we) last saw the deceased alive on Aug 20 1960, and that death occurred at 2:30 A.M. from the causes and on the date stated above.																																												
22a. SIGNATURE					J. Bradley Saugharty					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>					MED. DIRECTOR <input type="checkbox"/>					STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED																			
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS																																		
23a. BURIAL, CREMATION, REMOVAL (Specify)					Burial					23b. DATE THEREOF					8/25/60					23c. NAME OF CEMETERY OR CREMATORY					Mountain View Cemetery					Pueblo, Colo.														
24. FUNERAL DIRECTOR'S SIGNATURE					Howard H. Hubbard					ADDRESS					4107 Wilkens Ave.					25a. REC'D BY REGISTRAR					AUG 23 '60					25b. REGISTRAR'S SIGNATURE					Arthur S. Harris									

1931

1931

Baltimore

Baltimore

Arbiters

Arbiters

4201 Lombard Rd.

4201 Lombard Rd.

8/2/30

Elia M. Turner

July 27, 1931

Female White

Low

Home

Howardsville

Katherine Tonia

Robert B. Rye

Thomas C. Nellie, 4201 Lombard Rd.

none none

Arbiters

Arbiters: New Cemetery, Pottsville, Pa.

Howard W. Hubbard, #107 Wilkins Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8944
CERTIFICATE OF DEATH

10063

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANN ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Rt#6 BOX 291 PASADENA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 02X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First		Middle V.		Last TYNAN		4. DATE OF DEATH Month 8 - Day 28 - Year 1960	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-23-91	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JAMES TYNAN		14. MOTHER'S MAIDEN NAME BRIDGETT LAWLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 218-12-6526		INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 YEAR							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 7-28-1960 to 8-28-1960 that I last saw the deceased alive on 8-28-1960 and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Newcomer		ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____					
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Sept. 2, 1960		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Stephen's Cemetery		22d. LOCATION (City, town or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Newell		ADDRESS Pikesville		24a. REC'D BY REGISTRAR SEP 8 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-22

35

CERTIFICATE OF DEATH

8344

MARY ANN RYAN

10-22-35

10-22-35

10-22-35

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10-22-35

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8945

CERTIFICATE OF DEATH

Reg. Dist. No.

08917

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u> c. LENGTH OF STAY IN 1b <u>10 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>116 Hawthorne Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville 8, Md.</u> d. STREET ADDRESS <u>116 Hawthorne Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>May</u> Last <u>Uhler</u>				4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>19 60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 27, 1874</u>		9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Christian Berg</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Pyle</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Pikesville 8, Md.</u> <u>Mr. Charles E. Uhler, 116 Hawthorne Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/11/1960</u> , to <u>8/12/1960</u> , that I last saw the deceased alive on <u>8/11/1960</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Gerald N. Maggid</u> M.D.				ADDRESS (Street, city or town, state) <u>1401 Reisterstown Rd. Pikesville 8, Md</u>				DATE SIGNED <u>8/12/60</u>	
PHYSICIAN'S NAME (Type) <u>GERALD N. MAGGID, M. D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				ADDRESS <u>Pikesville 8, Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02313

CENTRAL GO. DIVISION

8012

TO THE DIRECTOR, BUREAU OF HEALTH SERVICES
FROM THE CHIEF, CENTRAL GO. DIVISION
SUBJECT: [Illegible]

[Illegible handwritten text, possibly a signature and date]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8946

CERTIFICATE OF DEATH

08918

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2mth6dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3338 Kerry Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Seymour		First Middle Last Vanderporten		4. DATE OF DEATH Month August Day 26 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1892		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoe salesman		10b. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Vanderporten				14. MOTHER'S MAIDEN NAME Bessie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 062-03-9663		17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Syndrome							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 14, 1960 to Aug. 26, 1960 that (I) (we) last saw the deceased alive on Aug. 26, 1960 , and that death occurred at 10:35 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Loretta Hsu				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-26-60	
22c. PHYSICIAN'S NAME (Type) Loretta Hsu, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Aug 26/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron		23d. LOCATION (City, town, or county) (State) New York, N. Y.	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc 6010 Reist. Road				25a. REC'D BY REGISTRAR DATE AUG 29 1960		25b. REGISTRAR'S SIGNATURE Arthur L. Hsu	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0018

CERTIFICATE OF BIRTH

1948

Signature: [illegible]

Signature: [illegible]

Signature: [illegible]

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8947

CERTIFICATE OF DEATH

08919

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MASS.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>1 yr 4 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>B.</u> Last <u>Van Dusen</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Channel</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Perrin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized + cerebral arteriosclerosis</u>							
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
19a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20a. (City or town)				20b. (County)		20c. (State)	
21. I certify that I attended the deceased from <u>17 1/2 yrs</u> to <u>19</u> , that I last saw the deceased alive on <u>8/15/60</u> , 19 <u>60</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest C. Brown, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>1101 N. Calvert St.</u>			
PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr., M.D.</u>				DATE SIGNED <u>8/23/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>				22b. DATE THEREOF <u>8-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Valleau Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Ridgewood, New Jersey</u>				22e. (State) <u>N.J.</u>		22f. (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Road, Towson</u>				24a. REC'D BY REGISTRAR <u>AUG 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Haskin</u>	

01920

CERTIFICATE OF DEATH

8947

I

WITNESSES

8-2-50

WITNESSES, one, J. H. ...

1 08920 Item 16 Film G269 8-26-60 et 8948 MDARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home		d. STREET ADDRESS 2027 E. 31st St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARRY F. WAGNER		4. DATE OF DEATH Month Day Year August 5, 1960 19			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1892	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Ret.		10b. KIND OF BUSINESS OR INDUSTRY DRUG Co.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY					
13. FATHER'S NAME Martin Wagner			14. MOTHER'S MAIDEN NAME Not Known		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. W.W. 1 Unknown		INFORMANT Address Robert Wagner-2027 E. 31st St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 25 April 1960 8/5/60	
20f. (City or town) 445R		20g. (County) (State)			
21. I certify that I attended the deceased from 8/1/60 to 8/5/60 , that I last saw the deceased alive on 8/1/60 , and that death occurred at 445R , from the causes and on the date stated above.					
ACTUAL SIGNATURE W.E. McCreth		M.D. 1303 Frederick Rd		DATE SIGNED 8/8/60	
PHYSICIAN'S NAME (Type) W.E. McCreth		Catonsville 28md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-60		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.	
22d. LOCATION (City, town, or county) Elkridge, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home, Catonsville, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the following information. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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8949

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08921

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville/ Baltimore 24</u>	
c. LENGTH OF STAY IN lb <u>7 yrs</u>		d. STREET ADDRESS <u>1212 Anglesea St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Catonsville Ridge Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur F. Walker</u>		4. DATE OF DEATH <u>August 25, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Sep.)	8. DATE OF BIRTH <u>Sept. 23, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Copper works</u>	
11. BIRTHPLACE (State or foreign country) <u>New York, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Walker</u>		14. MOTHER'S MAIDEN NAME <u>? ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mary Christian</u>		Address <u>1212 Anglesea St Balto 24</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>159X</u> IMMEDIATE CAUSE (a) <u>Gastro Intestinal Hemorrhage</u> DUE TO (b) <u>Cancer of GI tract</u> DUE TO (c) <u>unfron</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer Adeno Carcinoma</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> 19 <u>58</u> , to <u>8/25</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>8/25</u> 19 <u>60</u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff</u>		22b. DATE SIGNED <u>8/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF</u>		22d. ADDRESS <u>4605 Edmondson</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 27, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Schwartz' Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		25a. REC'D BY REGISTRAR <u>3000 E. Baltimore St.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur P. Hansen</u>		DATE <u>AUG 29 '60</u>	

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CENTRAL OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8950 Item 5 Film 0277 12-21-60 et

08922

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5623 Edmondson Ave</u>		d. STREET ADDRESS <u>5623 Edmondson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret B. Waring</u>		4. DATE OF DEATH <u>Aug. 25/60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1909</u>
9. AGE (In years, last birthday) <u>51</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleveland Clinic Balto.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lett Leroy Barclay</u>		14. MOTHER'S MAIDEN NAME <u>Clara H. Conroy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Geo. W. Wessel, 11 Ridge Rd. Catonsville</u>	
17. INFORMANT <u>Mrs. Geo. W. Wessel, 11 Ridge Rd. Catonsville</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerosis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes - mild - controlled by diet.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>1/2 hr.</u> <u>6 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 6, 1960</u> to <u>Aug. 26, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug. 26, 1960</u> , and that death occurred at <u>2:25</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas. Norton Jr.</u>		22b. DATE SIGNED <u>8/27/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. CHAS. NORTON, JR. M.D.</u>		22d. ADDRESS <u>5550 Balto. Nat'l Pike, 28.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/29/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Balto.</u>		23d. LOCATION (City, town, or county) (State) <u>29. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter F. W. 4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 29 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1882

ATTEST
CERTIFICATE OF DEATH

11

12

[Faint, mostly illegible handwritten text, likely a death certificate or legal document. The text is mirrored across the page, suggesting bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8951
CERTIFICATE OF DEATH

08923

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home		d. STREET ADDRESS Homewood Apts.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Brooks Warner		4. DATE OF DEATH Month Day Year August 26 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 4, 1870
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas E.O. Brooks		14. MOTHER'S MAIDEN NAME Angie Pegg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. C. Gardner Warner		Address 7115 Bristol Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Degenerative C.V. Disease 420.1 DUE TO Coronary sclerosis Ch. Myocardial Damage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Congestive heart failure (c) Semility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 19 47 to 26 Aug. 19 60 , that (I) (we) last saw the deceased alive on 26 Aug. 19 60 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph E. Muse, Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph E. Muse, Jr.		22d. ADDRESS 2725 N. Charles Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8-29-60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.		25a. REC'D BY REGISTRAR AUG 29 '60	
ADDRESS 1900 Eutaw Place		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

08233

CERTIFICATE OF DEATH

8233

(1)

Full Name of Deceased

Age

Sex

Marital Status

Occupation

Residence

Date of Death

Place of Death

Cause of Death

Signature of Registrar

Signature of Medical Officer

Signature of Coroner

Signature of Police Officer

Signature of Witness

Signature of Deceased

Signature of Next of Kin

Signature of Burial Officer

Signature of Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8952 Item 9 Film 269 9-1-60 et
CERTIFICATE OF DEATH

Reg. Dist. **88924**
 o. STATE **Maryland** b. COUNTY **Balto. County**

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home		e. STREET ADDRESS 301 Church Lane	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Edward First Dilworth Middle Watts Last Sr.		4. DATE OF DEATH Month August Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 6, 1884
9. AGE (In years last birthday) 75 1/2 yrs.		IF UNDER 1 YEAR Months 7 Days 17 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capt. Retired		10b. KIND OF BUSINESS OR INDUSTRY Fire Dept.	11. BIRTHPLACE (State or foreign country) Pikesville 8, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Henry Milton Watts	
14. MOTHER'S MAIDEN NAME Hannah Dilworth		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give date or dates of service)	
16. SOCIAL SECURITY NO. 218-28-0992		INFORMANT Address Mrs. Eliz. Maude Watts same address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) Years		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 7, 1956 to Aug. 12, 1960 , that I last saw the deceased alive on August 10, 1960 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pikesville, Maryland DATE SIGNED Aug 13, 1960 ACTUAL SIGNATURE Charles E. McWilliams M.D. Registrar PHYSICIAN'S NAME (Type) Charles E. McWilliams			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 15, 1960	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville 8 Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H Newell		24a. REC'D BY REGISTRAR Aug 16 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHIEF OF DEPT.

1892

(M)

Handwritten notes and signatures, including a large signature at the bottom.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08925

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARY LAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 152 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3947 SINCLAIR LANE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle G Last SR. WATTS				4. DATE OF DEATH Month AUGUST Day 23 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-26		9. AGE (In years lost birthday) yrs. 34		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE PRESS		11. BIRTHPLACE (State or foreign country) Wilmington NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JUDGE T. WATTS				14. MOTHER'S MAIDEN NAME ETTA RUSSELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-11		16. SOCIAL SECURITY NO. 238-26-6667		17. INFORMANT Address CLIN REC VAH BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) ADENOCARCINOMA, LEFT LUNG DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH RECENT 9 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 24 , 19 60 , to August 23 , 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 23 , 19 60 , and that death occurred at 3:30 P. M., from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick S. Donaldson</i>				22b. DATE 8/24/60		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/26/60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home				ADDRESS 3331 Brehms Lane Baltimore 13 Md		25a. REC'D BY REGISTRAR DATE AUG 25 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

VR A1S (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08926

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines 16 Tustling Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Margaret Wehnert</u>				4. DATE OF DEATH Month Day Year <u>Aug. 28/60</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> Months Days Hours Min.		11. UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>		11a. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Kamm</u>				14. MOTHER'S MAIDEN NAME <u>Johanna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>Mr. Peter Siewicz, Rivers Beach Md</u>			
17. INFORMANT Address <u>Mr. Peter Siewicz, Rivers Beach Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease and metastases</u> <u>420.0</u> DUE TO <u>from cancer of uterus.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>from cancer of uterus.</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-10-54</u> 19 <u>54</u> to <u>8-28</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8-16-60</u> 19 <u>60</u> , and that death occurred at <u>8-28-60</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry S. Gimbel</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY S. GIMBEL</u>				22d. ADDRESS <u>605 Arundel Ave - Baltimore, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurelton Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, 29, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witke & Co. 4101 Edmondson Ave</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

05030

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. Some legible fragments include:]

John ...
born ...
 died ...
 Cause of death ...
 Buried ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8955 CERTIFICATE OF DEATH

08927

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonoville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Caton Ridge Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George W. Weinkam</i>		DATE OF DEATH <i>Aug 26</i> 19 <i>60</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>9/20/85</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR: Months <i>7</i> Days <i>4</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ret.</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>212 10 3242</i>	
17. INFORMANT <i>Mrs Gloria Gettier</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>Arteriosclerotic Cardio Vasc. disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <i>Feb 28, 1966</i> to <i>August 26, 1960</i> , that (I) (we) last saw the deceased alive on <i>Aug 26, 1960</i> , and that death occurred at <i>5:00 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Harry K. Knipp</i>		22b. DATE SIGNED <i>8-27-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>HARRY K. KNIPP M.D.</i>		22d. ADDRESS <i>4116 Edmondson Ave. #29</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried Aug 29, 60</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Marshall + Son</i>		25a. REC'D BY REGISTRAR <i>28</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		DATE <i>AUG 30 '60</i>	

08937

CERTIFICATE OF DEATH

88937

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or medical report.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8801

CERTIFICATE OF DEATH

Reg. Dist. No.

08928

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 27		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4501 Poplar Avenue		e. STREET ADDRESS 4501 Poplar Avenue f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle E. Last Willard		4. DATE OF DEATH Month August Day 22 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1884
9. AGE (In years birth day) 75 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George T. Willard	
14. MOTHER'S MAIDEN NAME Mary Helen Harding		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna J. Harding, 4501 Poplar Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 422.1 DUE TO CEREBRAL ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE DUE TO ARTERIO SCLEROSIS (c) ARTERIO SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 1 DAY 14 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL ASTHMA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 Nov. , 19 60 , to 22 Nov. , 19 60 , that I last saw the deceased alive on 22 Nov. , 19 60 , and that death occurred at 9:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 682 Washington Bldg Baltimore DATE SIGNED ACTUAL SIGNATURE Edward F. Milan M.D. PHYSICIAN'S NAME (Type) EDWARD F. MILAN, M.D. BALTIMORE-30 MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-27-60	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE AUG 25 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08929

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wiltonwood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DOROTHY D. WILLIAMS		4. DATE OF DEATH Month Aug. Day 8. Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1896
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert L. Dryden		14. MOTHER'S MAIDEN NAME Marion Wetherill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. James E. Williams - Stevenson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTASIS DUE TO " Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Right upper lobe Lung (b) Carcinoma Left Breast (c) " PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) " INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr. 5 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 15, 1960 to June 2, 1960 , that (I) (we) last saw the deceased alive on 7-29 19 60 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE William L. Fearing		22b. DATE SIGNED 8-10-60	
22c. PHYSICIAN'S NAME (Type) WILLIAM L. FEARING		22d. ADDRESS 3025 Belair Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/11/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City, town, or county) (State) Balto., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Dickner & Sons - Balto		25a. REC'D BY REGISTRAR DATE AUG 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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OFFICE OF THE ATTORNEY GENERAL

STATE



GOVERNMENT

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8957

08930

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u> c. LENGTH OF STAY IN 1b <u>6 Days</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>812 Bentalou Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MANLEY</u> <u>---</u> <u>WILLIAMS</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>10</u> <u>1960</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1910</u>		9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>				11. BIRTHPLACE (State or foreign country) <u>Hartsville, S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ephron Williams</u>						14. MOTHER'S MAIDEN NAME <u>Mary Richardson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. _____				17. INFORMANT Address <u>Veterans Adm. Hosp. BALTO. 18, MD., Ft. Howard Division</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____			
21. I certify that (If (this hospital) attended the deceased from <u>August 4, 1960</u> to <u>August 10, 1960</u> , that (we) last saw the deceased alive on <u>Aug 10, 1960</u> , and that death occurred at <u>3:15</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>George C. McElpatrick</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/10/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>GEORGE C. MC ELPATRICK, M.D.</u>						22d. ADDRESS <u>VAH, BALTO. MD. - FT HOWARD DIVISION</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/15/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Baltimore 28, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u>						1800 N. Monroe St. <u>Baltimore 17, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

63

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8958

CERTIFICATE OF DEATH

Reg. Dist. No. 08931

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loreley</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Williams</u> Last		4. DATE OF DEATH Month <u>Aug.</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Distillery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-01-7834</u>	
17. INFORMANT Address <u>Campbell Williams, Loreley Rd., White Marsh, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			INTERVAL BETWEEN ONSET AND DEATH <u>2-yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1, 1959</u> to <u>Aug. 19, 1960</u> , that I last saw the deceased alive on <u>Aug. 19, 1960</u> , and that death occurred at <u>8:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fred O. Hodous</u> M.D.		DATE SIGNED <u>Edgewood</u>	
PHYSICIAN'S NAME (Type) <u>Fred O. Hodous</u>		<u>Edgewood Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 23, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		22d. LOCATION (City, town, or county) (State) <u>Loreley Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward K. M. Brown</u>		24a. REC'D BY REGISTRAR <u>Aug 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Edward K. M. Brown</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

26029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8:55:1
CERTIFICATE OF DEATH

08932

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 6 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) First NETA Middle BURNHAM Last WILLIAMSON		4. DATE OF DEATH Month AUG Day 8 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-5-1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WALTER COOK BURNHAM		14. MOTHER'S MAIDEN NAME HATTIE C. ROBERTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-16-6053	
17. INFORMANT Frank Z. Smith Address Cockeysville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Arterio Sclerotic Cardio Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-17 19 60 , to 8-8 19 60 , that (I) (we) last saw the deceased alive on 8-8 19 60 , and that death occurred at 9A M, from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 8/8/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF 8-11-60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR AUG 10 '60	
25b. REGISTRAR'S SIGNATURE Arthur E. Kenna			

82083

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8900

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08933

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 101 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Catonsville) 28 d. STREET ADDRESS 1416 Woodcliff Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ANDREW Middle J. Last WINDFELDER		4. DATE OF DEATH Month August Day 2 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 7, 1916	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 44	IF UNDER 24 HRS. Days 44 Hours 44 Min. 44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Keeper		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Drugs		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George Windfelder		14. MOTHER'S MAIDEN NAME Sophia Kaltenback				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 220-03-9404		17. INFORMANT Clinical Records, VAH, Baltimore 18, Md. Ft. Howard Address Division		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT MELANOMA 1909 XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTASIS TO THE RIGHT TEMPORAL LOBE OF THE BRAIN 6 MONTHS XXXXX (c) PYELONEPHRITIS 3 WEEKS						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from April 23, 1960 to August 2, 1960 , that (H) (we) last saw the deceased alive on August 2, 1960 , and that death occurred at 10:20 A. M., from the causes and on the date stated above.						
22a. SIGNATURE Walter J. Pijanowski		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 8/2/60		
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-6-60		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE George A. Farley, Frederick And Shady Nook Aves.		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris

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CENTRICAL OF DEATH

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(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8961

CERTIFICATE OF DEATH

Reg. Dist. No. 08934

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> <u>LANDSDOWNE -27-</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANDSDOWNE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANDSDOWNE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2334 MONUMENTAL RD</u>				-d. STREET ADDRESS <u>2334 MONUMENTAL RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN</u> <u>WISCHHUSEN</u>				4. DATE OF DEATH Month Day Year <u>AUG</u> <u>19</u> <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG-18-1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MARITIME GUARD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.R.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217-05-2316</u>		17. INFORMANT <u>RECORDS.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 stroke</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 stroke</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>obesity</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> NOT while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 1959</u> to <u>Aug. 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 19</u> , 19 <u>60</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Florian P. Nadolski</u> M.D.				ADDRESS (Street, city or town, state) <u>2703 Hammond's Ferry Rd</u>			
PRINTED NAME (Type) <u>Florian P. Nadolski</u>				DATE SIGNED <u>Baltimore 27, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>8-22-60</u>		<u>GLEN HAVEN CEMETERY</u>		<u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Kacharskas</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5090

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8962

CERTIFICATE OF DEATH

Reg. Dist. No.

08935

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cheryl Ave</u>				d. STREET ADDRESS <u>Cheryl Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>H</u> Last <u>Wooden Sr.</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Jan 30 1885</u>		9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR: Months <u>8</u> Days <u>15</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edge Aren.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William Wooden</u>					
14. MOTHER'S MAIDEN NAME <u>Capitolia ? Roberson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					
16. SOCIAL SECURITY NO. <u>220-20-7998</u>		17. INFORMANT Address <u>Corrinne C. Wooden Cheryl Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho-PNEUMONIA</u> 422.1 DUE TO <u>Arteriosclerotic Cardiovascular Dis. 8 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8 yrs.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>5:28</u>					
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/14</u> , 19 <u>52</u> , to <u>8/16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/16</u> , 19 <u>60</u> , and that death occurred at <u>5:28</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>		DATE SIGNED <u>FORK, MD.</u>					
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 19 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST STEPHEN'S CEM</u>			
22d. LOCATION (City, town, or county) <u>BRAD SHAW</u>		22e. (State) <u>MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Doppel Bros</u>		ADDRESS <u>7110 BELAIR RD.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 18 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

1902



Form with multiple sections for recording death information, including fields for name, age, sex, date of death, and cause of death. The form is filled out with handwritten text.

DECEASED

NAME [Handwritten Name]

AGE [Handwritten Age]

SEX [Handwritten Sex]

DATE OF DEATH [Handwritten Date]

PLACE OF DEATH [Handwritten Place]

Cause of Death [Handwritten Cause]

Signature of Physician [Handwritten Signature]

Signature of Registrar [Handwritten Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8963

CERTIFICATE OF DEATH

Reg. Dist. No. 08936

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4				c. LENGTH OF STAY IN 1b 55 Towson 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1901 Glen Ridge Road				d. STREET ADDRESS 1901 Glen Ridge Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Marian Middle B. Last Wright				4. DATE OF DEATH Month August Day 10 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1912	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 48 Days 48 Hours 48 Min. 48		IF UNDER 24 HRS. Months 48 Days 48 Hours 48 Min. 48			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Francis A. Reck				14. MOTHER'S MAIDEN NAME Katherine Hartman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-01-1142			
17. INFORMANT Thelma Younger, 1901 Glen Ridge Road				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH Sudden death in sleep. Unknown.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 17, 1960 , to Aug. 10, 1960 , that I last saw the deceased alive on Aug. 5, 1960 , and that death occurred at 8 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 East Read St. Baltimore DATE SIGNED Aug. 11, 1960							
ACTUAL SIGNATURE Edward F. Cotter M.D.				DATE SIGNED Aug. 11, 1960			
PHYSICIAN'S NAME (Type) Edward F. Cotter, M.D.				ADDRESS 6 East Read Street			
22a. BURIAL, CREMATION, (Specify) BURIAL		22b. DATE THEREOF 8-13-60		22c. NAME OF CEMETERY OR CREMATORY Moreland Park		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR AUG 12 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

1903

NAME OF DECEASED J. Edgar Hoover		RESIDENCE Washington, D.C.	
DATE OF DEATH April 1, 1903		PLACE OF DEATH Washington, D.C.	
AGE 45		SEX Male	
CAUSE OF DEATH Typhoid fever		DISEASE OR INJURY Typhoid fever	
DATE OF BIRTH March 1, 1858		PLACE OF BIRTH Albany, New York	
MARRIAGE Married		SPOUSE Mary Jane Hoover	
OCCUPATION Special Agent in Charge, U.S. Department of Justice		EDUCATION Bachelor of Science, Johns Hopkins University	
RELIGION Methodist		BAPTISM Yes	
BURIAL Buried		CEMETERY Arlington National Cemetery	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF MINISTER J. Edgar Hoover	
SIGNATURE OF CORONER J. Edgar Hoover		SIGNATURE OF JURY J. Edgar Hoover	
DATE April 1, 1903		PLACE Washington, D.C.	

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